

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05279

5286

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Baltimore (Rural)</u>				OR TOWN <u>Baltimore</u> <u>3701-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wayne Nursing Home</u> <u>98 Smithwood Ave.</u>				STREET ADDRESS (If rural give location) <u>2500 Blk N. Charles St.</u> ✓			
3. NAME OF DECEASED: (First) <u>John</u> (Middle) <u>E.</u> (Last) <u>Ackerman</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>June 21,</u> <u>19</u> <u>55</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Divorced</u>	8. DATE OF BIRTH: <u>July 3, 1883</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Salesman</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Jewelery</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>212-01-1250</u>		17. INFORMANT & ADDRESS: <u>Mr. Gerald Ackerman - Ashton, Md.</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Congestive Heart Failure</u>							
ANTECEDENT CAUSE (S) (B) <u>Degenerative Heart Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Terminal Pneumonia</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M.</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>54 21 June 55</u>			
22. I hereby certify that I attended the deceased from <u>1955</u> to <u>21 June 55</u> , that I last saw the deceased alive on <u>20 June 1955</u> , and that death occurred at <u>7:50 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		ADDRESS <u>1707 Edmondson Ave. Catonsville, Md.</u>		DATE SIGNED <u>6/21/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/24/55</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6-20-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR ADDRESS <u>JOHN F. DENNY, INC. 715 Light St.</u>			

Dr E. W. McGowan.  
Care 1709 Edmunds Ave.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

5287

## CERTIFICATE OF DEATH

05280

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore (Rural)</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore (Rural)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>634 Overbrook Rd.</u>		STREET ADDRESS (If rural, give location) <u>634 Overbrook Rd.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Milton</u> (Middle) <u>Howard</u> (Last) <u>Albert</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>June 19, 1955</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH (Specify) <u>5/9/06</u> AGE last birthday <u>49</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Telephone Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u></u>	
13. FATHER'S NAME <u>Charles Albert</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Schwemm</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u></u>	
17. INFORMANT AND ADDRESS <u>Mrs. Milton Albert 634 Overbrook Rd</u>		<u></u>	

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

162X Immediate cause

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a)

(b)

(c)

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION

January 1, 1955

#### 19b. MAJOR FINDINGS OF OPERATION

Metastatic Carcinoma of Lung, Right - Rib metastasis

#### 20. AUTOPSY?

Yes ☐ No ☒

#### 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While at Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept., 1950, to June 19, 1955, that I last saw the deceased

alive on June 18, 1955, and that death occurred at 1:10 A.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

#### 23. BURIAL, CREMATION REMOVAL (Specify)

Burial

#### DATE THEREOF

6/22/55

#### NAME OF CEMETERY OR CREMATORY

Cedar Hill Cem

#### LOCATION (City, town, or county)

Baltimore, Md.

(State)

#### DATE REC'D BY LOCAL REG.

6-20-55

#### REGISTRAR'S SIGNATURE

A. W. Hedrick

#### 24. FUNERAL DIRECTOR

JOHN F. DUNNY, INC.

#### ADDRESS

715 Light St.

Baltimore-30, Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Geo. J. R.

5288

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: Spring Grove State Hospital COUNTY Baltimore 28 MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Catonsville HOSPITAL OR INSTITUTION OR STREET ADDRESS 14 Spring Grove State Hosp.				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Baltimore CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pikesville STREET ADDRESS (If rural give location) 605 Upland Road									
3. NAME OF DECEASED: (Type or Print) (First) Jane (Middle) Kingsbury (Last) Allen		4. DATE (Month) (Day) (Year) OF DEATH: 6 19 1955		5. SEX: female		6. COLOR OR RACE: W		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed		8. DATE OF BIRTH: 11/29/ 1866		9. AGE last birthday 88 Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife				10B. KIND OF BUSINESS OR INDUSTRY: at home				11. BIRTHPLACE (State or foreign country): N. J.				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Henry A. Kingsbury						14. MOTHER'S MAIDEN NAME: Sarah Hutchinson							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) 4 no				16. SOCIAL SECURITY NO. none				17. INFORMANT & ADDRESS: Mrs. Janet A. Zouck 605 Upland Road, Pikesville, Md.					
18. MEDICAL CERTIFICATION												INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 175X IMMEDIATE CAUSE (A) Uremia; bilateral pyohydronephrosis ANTECEDENT CAUSE (B) Multiple abdominopelvic metastases DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Right ovarian cystocarcinoma												weeks months unknown	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Arteriosclerotic cardiovascular disease												years	
19A. DATE OF OPERATION: 2				19B. MAJOR FINDINGS OF OPERATION								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY atreet, office bldg., etc.)				21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?					
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from 8-12, 1954, to 6-19, 1955, that I last saw the deceased alive on 6-18, 1955, and that death occurred at 8:35 AM, from the causes and on the date stated above. SIGNATURE L. Shyne Williams ADDRESS M. D. Spring Grove State Hospital DATE SIGNED 6-19-55													
23. BURIAL CREMATION, REMOVAL (SPECIFY) Cremation				DATE THEREOF 6/21/55				NAME OF CEMETERY OR CREMATORY Green Mount Crem.				LOCATION (City, town, or county) Balto., Md.	
DATE REC'D BY LOCAL REGISTRAR 6-21-55				REGISTRAR'S SIGNATURE A. W. Adams				FUNERAL DIRECTOR M. J. Thomas & Sons				ADDRESS	

MARGIN RESERVED FOR BINDING

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VILLAGE  
OF  
ROOSEVELT  
ISLAND  
NEW YORK  
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## 5289 CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Balto.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<input checked="" type="checkbox"/> TOWN <u>Woodlawn</u>		OR TOWN <u>Woodlawn</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2613 Purnell Drive</u>		STREET ADDRESS (If rural give location) <u>2613 Purnell Drive</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>ADA AGNES ALLISON</u>		DEATH: <u>June 1, 1955</u>	
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Nov. 3, 1869</u>
9. AGE last birthday: <u>85</u> yrs.		10. UNDER 1 YEAR: Months Days	11. UNDER 24 HRS.: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>at home</u>	11. BIRTHPLACE (State or foreign country): <u>Virginia</u>
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME: <u>James C. Bryant</u>		14. MOTHER'S MAIDEN NAME: <u>Catherine J. Wright</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS: <u>Mr. Raleigh W. C. Allison-4943 Cedar Ave.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Cancer Breast - Adenocarcinoma</u>			<u>2 yrs</u>
ANTECEDENT CAUSE (S): (B) <u>C.P.C. Lung &amp; Kidney</u>			<u>4 da</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR?	(County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 1, 1955</u> , to <u>June 1, 1955</u> , that I last saw the deceased alive on <u>June 1, 1955</u> , and that death occurred at <u>6:05 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Dr. E. M. Team</u>		DATE SIGNED <u>June 1, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/4/55</u>	NAME OF CEMETERY OR CREMATORY <u>Farnham Baptist Cem.</u>
LOCATION (City, town, or county) <u>Downings, Va.</u>		(State)	
DATE REC'D BY LOCAL REGISTRAR <u>6-3-55</u>	REGISTRAR'S SIGNATURE <u>R. W. Hedgcock</u>	24. FUNERAL DIRECTOR <u>Wm. J. Dickener &amp; Sons</u>	ADDRESS <u>1717</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

OFFICE OF THE SECRETARY OF THE ARMY

WASHINGTON, D. C.

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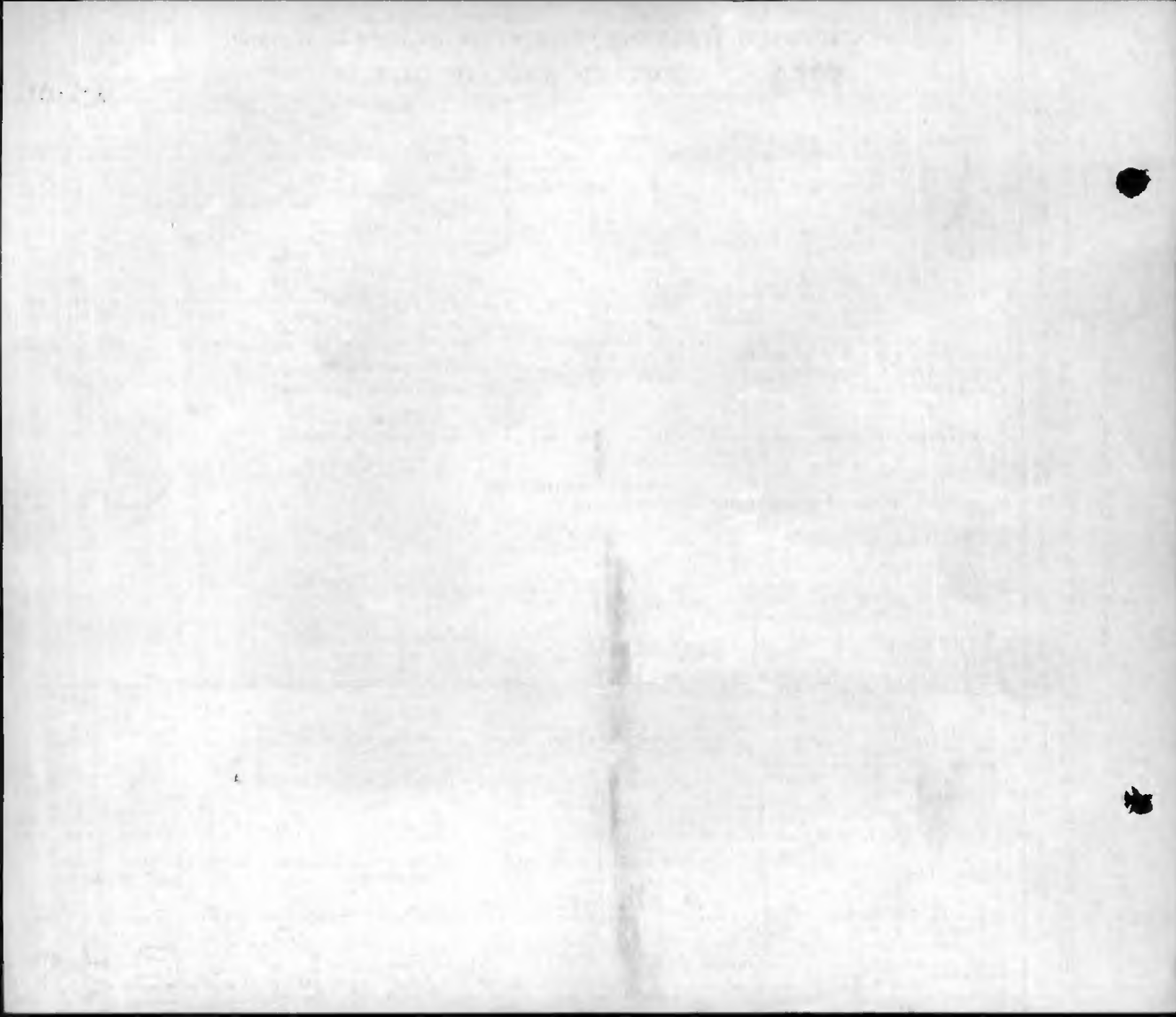
## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>52 Catonsville</u>	LENGTH OF STAY (in this place) <u>1 mo. 12 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove State Hospital</u>	STREET ADDRESS (If rural give location) <u>Catonsville Nursing Home</u> No better address		
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Maudie E. Amendt</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>June 14, 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>2-19-1877</u>
9. AGE last birthday <u>78</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wife of Dr. Anderson</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country): <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Unknown</u>		14. MOTHER'S MAIDEN NAME: <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hosp.</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
331X IMMEDIATE CAUSE (A) <u>Generalized Arteriosclerosis</u>			
ANTECEDENT CAUSE (S) (B) <u>Diabetes Mellitus</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>260X</u> (C) <u>Cerebral Vascular Accident (thrombosis)</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-2</u> , 19 <u>55</u> , to <u>6-14</u> , 19 <u>55</u> that I last saw the deceased alive on <u>6-14</u> , 19 <u>55</u> , and that death occurred at <u>8:50</u> A.M. from the causes and on the date stated above.			
SIGNATURE <u>JR. Brown</u>		DATE SIGNED <u>6-14-55</u>	
ADDRESS <u>Spring Grove State Hospital</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/16/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Balto.</u>		LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>15-55</u>		REGISTRAR'S SIGNATURE <u>Dr. W. Hedrick</u>	
FUNERAL DIRECTOR <u>Cook Inc.</u>		ADDRESS <u>1217 St. Paul St.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:		Baltimore		COUNTY		Baltimore		CITY (if outside corporate limits, write RURAL and give nearest town) OR TOWN and give nearest town)		X		HOSPITAL OR INSTITUTION OR STREET ADDRESS		613 Overbrook Rd.		3. NAME OF DECEASED: (Type or Print)		LESTER W. ANDERSON		4. DATE (Month) (Day) (Year) OF DEATH: June 13, 1955		5. SEX: male		6. COLOR OR RACE: white		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married		8. DATE OF BIRTH: April 7, 1908		9. AGE last birthday: 47 yrs. Months Days Hours Min.		10. USUAL OCCUPATION (give kind of work done during most of working life, even if retired): maker		11. BIRTHPLACE (State or foreign country): Ill.		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME: Alfred Anderson		14. MOTHER'S MAIDEN NAME: Christine		15. SOCIAL SECURITY NO.		16. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service): No		17. INFORMANT'S NAME AND ADDRESS: Mrs. Olga M. Anderson-613 Overbrook Rd.		18. MEDICAL CERTIFICATION: I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) Antecedent Cause (B) Diseases or conditions, if any, giving rise to the above cause (C) Other significant conditions contributing to the death but not related to the disease or condition causing death. 19. DATE OF OPERATION: 20. AUTOPSY: YES NO		21. TIME (Month) (Day) (Year) (Hour) OF INJURY: 22. I hereby certify that I attended the deceased from June 13, 1955, and that death occurred at 8:30 PM, from the causes and on the date stated above. DATE SIGNED: 23. BURIAL, CREMATION, REMOVAL (specify): Bural 24. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner): 25. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY OCCURRED: 26. HOW DID INJURY OCCUR? at work at work		27. NAME OF CEMETERY OR CREMATORY: M.O. 7501 York Rd. Location (City or town) (State): Baltimore, Md. 28. DATE THEREOF: 6/17/55 29. REGISTRAR'S SIGNATURE: 30. REGISTRAR: 31. ADDRESS: 32. DATE REC'D BY LOCAL REGISTRAR: 6-15-55	
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## CERTIFICATE OF DEATH

5291

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 0528

Reg. Dist. No.



## MARYLAND STATE DEPARTMENT OF HEALTH

0528!

5292

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 3

1. PLACE OF DEATH- COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Md. COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Catonsville,		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore,	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pines Nursing Home, 16 Fusting Ave.		STREET ADDRESS 21 N. Monastery Ave. (If rural, give location)	
3. NAME OF DECEASED (Type or Print) Walter Francis Appleby,		4. DATE OF DEATH June 25, 1955	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widower	8. DATE OF BIRTH May 21, 1886
9. AGE last birthday 69 yrs.		10. BIRTHPLACE (State or foreign country) Washington, D. C.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Police Sargent.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Israel D. Appleby		14. MOTHER'S MAIDEN NAME Mary Frances Habberset	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY No. 213-28-1864	
17. INFORMANT AND ADDRESS Mrs. Dorothy R. Stallings, 3321 Shelbourne Rd			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause 331X Cerebral thrombosis		4 hrs
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 2 hypertension		2 yrs
(c) 260X Diabetes Mellitus		3 yrs

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office hldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/10/55, 19....., to June 25, 1955, that I last saw the deceased alive on June 23, 1955, and that death occurred at 10:30 A.m., from the causes and on the date stated above.

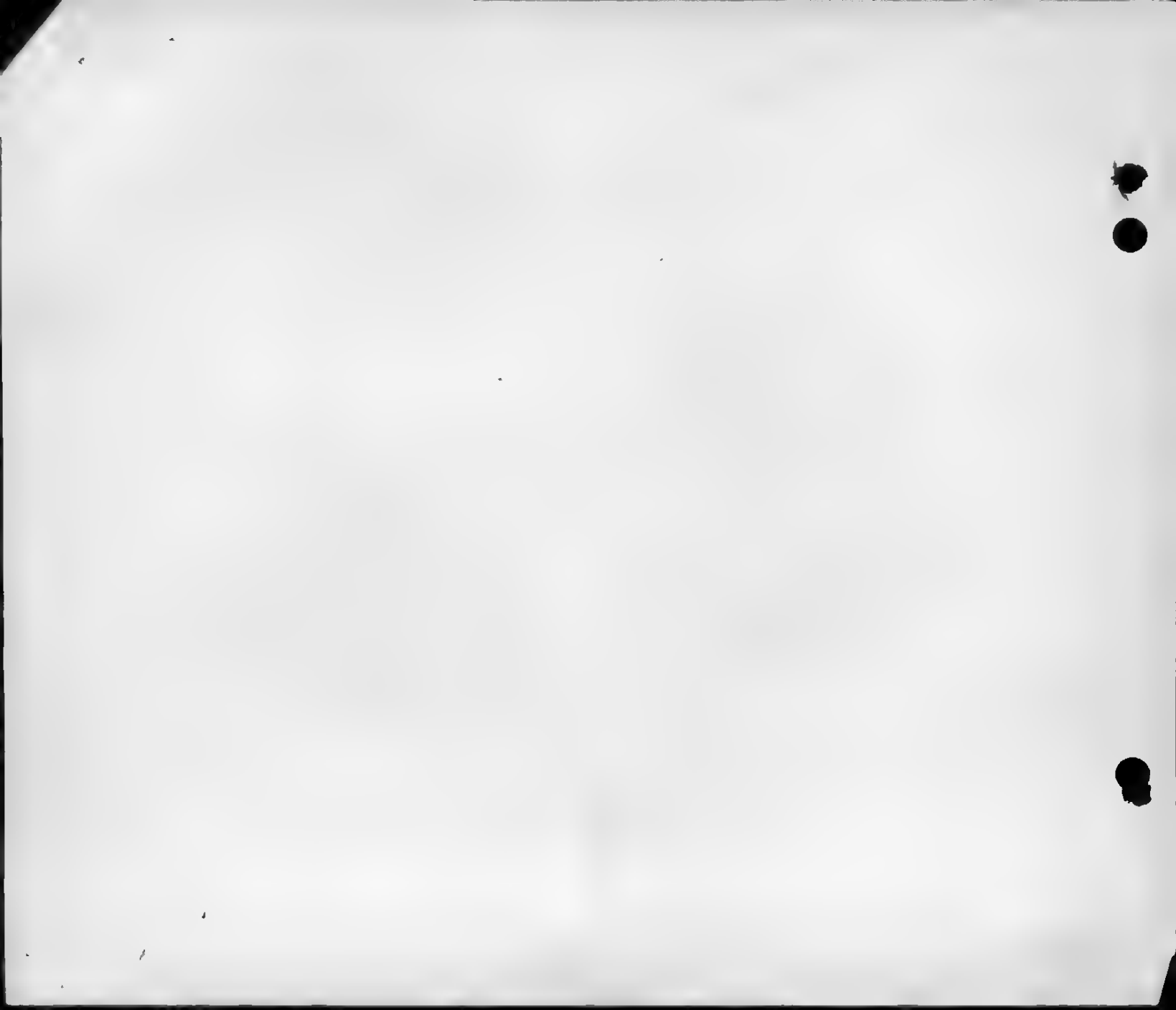
SIGNATURE: J. M. Katzberger 4123 Frederick Ave. June 1955

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF JUN 28 1955	NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery,	LOCATION (City, town, or county) Baltimore, Md. (State)
DATE REC'D BY LOCAL REG. 6-28-55	REGISTRAR'S SIGNATURE J. M. Katzberger	24. FUNERAL DIRECTOR Vernon L. Lamm	ADDRESS 4611 Park Heights Ave. Baltimore, Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## CERTIFICATE OF DEATH

Reg. Dist. No. 41

5272

05286

## 1. PLACE OF DEATH:

COUNTY Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town)

53 Dundalk

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS

6906 Brentwood Ave.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland

COUNTY F.

CITY (If outside corporate limits, write RURAL and give nearest town)

53 Dundalk

STREET ADDRESS

(If rural give location)

6906 Brentwood Ave.

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

OTTO

A.

BAKER

## 4. DATE OF DEATH:

(Month)

(Day)

(Year)

June 16, 1955

## 5. SEX:

Male

## 6. COLOR OR RACE:

White

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

Widowed

## 8. DATE OF BIRTH:

July 19, 1883

## 9. AGE last birthday:

71 yrs.

## IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

## 10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired:

Millwright

## 10b. KIND OF BUSINESS OR INDUSTRY:

Bethlehem Steel Co.

## 11. BIRTHPLACE (State or foreign country):

Germany

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME:

August Baker

## 14. MOTHER'S MAIDEN NAME:

Anna ?

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No.

## 16. SOCIAL SECURITY No.:

213-09-0586

## 17. INFORMANT &amp; ADDRESS:

Mrs. Robert Shaw 6906 Brentwood Ave.

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause

(a) DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

(c)

Coronary thrombosis  
myocarditis, chronic  
arteriosclerosis

Interval Between Onset And Death

5 min

2 mo.

1 year

2 mo.

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Left leg amputated due to embolism of artery

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY ?

Yes ☐ No ☒

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from May 29, 1955, to June 16, 1955, that I last saw the deceased

alive on June 16, 1955, and that death occurred at 11:30 AM

SIGNATURE

(Degree or title)

from the causes and on the date stated above.

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION, REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

## ADDRESS

June 18-1955

William M Kelly

Ullrich Funeral Home 2112 Dundalk Ave.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

WONKAW V. S.

UN 91 1955

DEAD

5293

## CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u> MARYLAND		CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>ESSEX</u>		STATE <u>MD.</u> COUNTY <u>BALTO</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>	
TOWN <u>ESSEX</u>		LENGTH OF STAY (in this place)		STREET ADDRESS (If rural, give location) <u>704 MYRTH AVE.</u>		STREET ADDRESS <u>704 MYRTH AVE.</u>	
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>NINA M. BARROW</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>JUNE 29 19 55</u>			
5. SEX: <u>FEM.</u>		6. COLOR OR RACE: <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH: <u>APR. 17-1868</u>	
9. AGE last birthday: <u>87</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country): <u>VERMONT</u>		12. CITIZEN OF WHAT COUNTRY? <u>?</u>	
13. FATHER'S NAME: <u>EDWARD MANWELL</u>				14. MOTHER'S MAIDEN NAME: <u>ELECTRA ANN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>HUNTER BARROW ABOVE</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Cerebral Hemorrhage</u>							<u>8 days</u>
Antecedent cause(s) (b) <u>Arterio-sclerotic cardio-</u>							<u>9 yrs</u>
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Vascular disease with hypertension</u>							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION:			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE		INJURY		INJURY OCCURRED While at . Not while work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR?	
TIME (Month) (Day) (Year) (Hour) OF INJURY		M.					
22. I hereby certify that I attended the deceased from <u>June 1946</u> , to <u>June 29 1955</u> , that I last saw the deceased alive on <u>June 28 1955</u> , and that death occurred at <u>6:30 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Joseph N. Walsh</u> (DEGREE OR TITLE) ADDRESS <u>423 Eastern Ave</u> DATE SIGNED <u>7/1/55</u>							
23. BURIAL, CREMATION REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF <u>July 2-55</u>		NAME OF CEMETERY OR CREMATORY <u>Meadowdale M.P.</u>		LOCATION (City, town, or county) (State) <u>Washington Blvd. Md.</u>	
DATE REC'D BY LOCAL REG. <u>7-2-55</u>		REGISTRAR'S SIGNATURE <u>Carl Hurler</u>		24. FUNERAL DIRECTOR <u>John G. Connelley</u>		ADDRESS <u>Beary Rd.</u>	

MARGIN RESERVED FOR BINDING.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

## NOTES

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5294

CERTIFICATE OF DEATH

Reg. Dist. No.

05287

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Catonsville</u>	LENGTH OF STAY (in this place) <u>18 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hosp</u>		STREET ADDRESS (If rural give location) <u>3025 Windsor Ave</u>	
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH:	
(First) <u>Zella</u> (Middle) <u>M.</u> (Last) <u>Bennett</u>		(Month) <u>June</u> (Day) <u>4</u> (Year) <u>1958</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M</u>	8. DATE OF BIRTH: <u>Dec. 1877</u>
9. AGE last birthday <u>77</u> yrs.		10. AGE last birthday: IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME: <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>unknown</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMATION & ADDRESS: <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Arterio-sclerotic cardio-vascular disease</u>		<u>Years</u>	
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic Brain Syndrome due to arteriosclerosis</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May 17, 1958</u> to <u>June 4, 1958</u> , that I last saw the deceased alive on <u>June 4, 1958</u> , and that death occurred at <u>12 P</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Frederick E. Thielges</u>		ADDRESS <u>Spring Grove Hosp</u>	
DATE SIGNED <u>6/4/58</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
Burial		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <u>6/7/58</u>		REGISTRAR'S SIGNATURE <u>Druid Ridge Cem.</u>	
FUNERAL DIRECTOR <u>Pikesville, Md.</u>		ADDRESS <u>Md</u>	

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5295

CERTIFICATE OF DEATH

Reg. Dist. No. 15288-2

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL, and give nearest town) <u>Pikesville</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>401 COLBY Road.</u>		STREET ADDRESS (If rural give location) <u>401 COLBY ROAD.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>FRITZ KARL BERNOT</u>		DATE OF DEATH: <u>JUNE 7 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Dec. 2 1886</u>
9. AGE last birthday: <u>68</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>PATTERNER</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Electrical - mfg.</u>	
11. BIRTHPLACE (State or foreign country): <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME: <u>OTTO Berndt.</u>		14. MOTHER'S MAIDEN NAME: <u>Unknown.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u>		16. SOCIAL SECURITY NO. <u>215-01-1279</u>	
17. INFORMANT & ADDRESS: <u>Mrs Fritz K. Berndt (wife) 401 COLBY ROAD, PIKEVILLE - 8</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Pulmonary Edema</u>		<u>2-3 mo</u>	
ANTECEDENT CAUSE (B) <u>Cor Pulmonale</u>		<u>5 yr or more?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Silicosis [lung]</u>		<u>5 yr or more?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>NONE</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>NONE</u>	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5 June</u> , 1955, to <u>7 June</u> , 1955, that I last saw the deceased alive on <u>7 June</u> , 1955, and that death occurred at <u>4:15 P</u> M, from the causes and on the date stated above.			
SIGNATURE <u>H. Patterson Mack</u>		DATE SIGNED <u>7 June 55</u>	
23. BURIAL, CREMATION, REMOVAL, (SPECIFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>McDonough</u>	
DATE REC'D BY LOCAL REGISTRAR <u>June 7-55</u>		FUNERAL DIRECTOR <u>Howard Co. Maryland</u>	
REGISTRAR'S SIGNATURE <u>Dr. Hedy</u>		ADDRESS <u>Pikesville</u>	

MARGIN RESERVE FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



5296

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

COUNTY BALTIMORE

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) 55 TOWSON

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS

7103 OXFORD ROAD

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MARYLANDCOUNTY 24CITY (If outside corporate limits, write RURAL and give nearest town) 17X2OR TOWN CENTERVILLE

STREET ADDRESS (If rural give location)

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

JAMESE.BRAMBLE

## 4. DATE OF DEATH:

(Month)

(Day)

(Year)

JUNE 7, 1955

## 5. SEX:

## 6. COLOR OR RACE:

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

## 8. DATE OF BIRTH:

## 9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

MALEWHITEWIDOWERJUNE 17, 187381

## 10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired.

## 10b. KIND OF BUSINESS OR INDUSTRY:

## 11. BIRTHPLACE (State or foreign country):

## 12. CITIZEN OF WHAT COUNTRY?

RET. GROCERRETAILMARYLANDUSA

## 13. FATHER'S NAME:

## 14. MOTHER'S MAIDEN NAME:

JAMES BRAMBLECATHERINE ERDMAN

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)

## 16. SOCIAL SECURITY No.:

## 17. INFORMANT &amp; ADDRESS:

NONONE219-14-3113AFAMILY RECORDS

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause

(a)

DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

Coronary ThrombosisGeneralized Arteriosclerosiswith Renal insufficiency

Interval Between Onset And Death

Sudden10 yrs

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

## INJURY OCCURRED

While at Work ☐Not While At Work ☐

## HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 1953, to June 6, 1955, that I last saw the deceasedalive on June 6, 1955, and that death occurred at 5:30 AM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION, REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

ADDRESS

June 8, 1955Mabel C. GrayJohn Burns Stone, Towson, Md.

MARGIN RESERVED FOR INDEXING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BUREAU V. S.

1914

1914

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **05290**  
**5297** CERTIFICATE OF DEATH

Reg. Dist. No. **37...**

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cockeysville Md 1 year 14 months</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rising Sun Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Masonic Home</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (Type or Print) <u>Stella Rhoda St. Briscoe</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>June 6 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. MARRIAGE: <u>WIDOWED</u>	8. DATE OF BIRTH: <u>Dec 11-1869</u>
9. AGE last birthday <u>85</u> yrs.		10. MONTHS <u>11</u>	11. DAYS <u>11</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
13. FATHER'S NAME: <u>Peter Hortenstein</u>		14. MOTHER'S MAIDEN NAME: <u>Sarah B. Jackson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Masonic Home Cockeysville Md</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Acute Sclerotic Heart Disease</u>			
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Dec 12, 1953</u> to <u>June 6, 1955</u> that I last saw the deceased alive on <u>June 6, 1955</u> , and that death occurred at <u>12:30 PM</u> from the causes and on the date stated above.			
SIGNATURE <u>Ruth J. Lees</u>		DATE SIGNED <u>6/6/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		24. FUNERAL DIRECTOR ADDRESS	
DATE REC'D BY LOCAL REGISTRAR <u>June 9, 1955</u>		REGISTRAR'S SIGNATURE <u>Laura M. Schroeder</u>	
NAME OF CEMETERY OR CREMATORY <u>Nottingham Church Yard, Rising Sun Md</u>		LOCATION (City, town, or county) (State) <u>Rising Sun Md</u>	
25. FUNERAL DIRECTOR ADDRESS			
26. FUNERAL DIRECTOR ADDRESS			

JOHN A. JONES

NO. 10 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5298

## CERTIFICATE OF DEATH

Reg. Dist. No.

05291

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>AA</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		LENGTH OF STAY (in this place) <u>56 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Annapolis</u>		<u>02.11.20</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>22 N. Lafayette Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>JOSEPH (NMI) BROWN</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>June 16, 19 55</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>3/8/78</u>	9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Cook</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>U.S. Naval Academy</u>		11. BIRTHPLACE (State or foreign country): <u>Annapolis, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME: <u>Joseph Brown</u>				14. MOTHER'S MAIDEN NAME: <u>Rachel Tyler</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) If Yes, give war or dates of service: <u>Yes</u> <u>OW-VMI</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>443X HYPERTENSIVE CARDIOVASCULAR DISEASE</u>						10 YEARS	
ANTECEDENT CAUSE (B) <u>DUE TO</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>DUE TO</u>							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>.VA</u> M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Apr. 21, 19 55</u> to <u>June 16, 1955</u> , that I last saw the deceased <u>on June 16, 1955</u> and that death occurred at <u>2:10 M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William B. VanDeGrift, M.D.</u>		M. D. <u>VAH, FORT HOWARD, MD.</u>		DATE SIGNED <u>7-17-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>6-19-55</u>		NAME OF CEMETERY OR CREMATORY <u>Brewer Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>June 19, 1955</u>		REGISTRAR'S SIGNATURE <u>Lawson L. Larkins</u>		24. FUNERAL DIRECTOR <u>William Reese Funeral Home</u>		ADDRESS <u>108 W. Washington St. Annapolis, Md.</u>	

THE AMERICAN

1904

5299

## CERTIFICATE OF DEATH

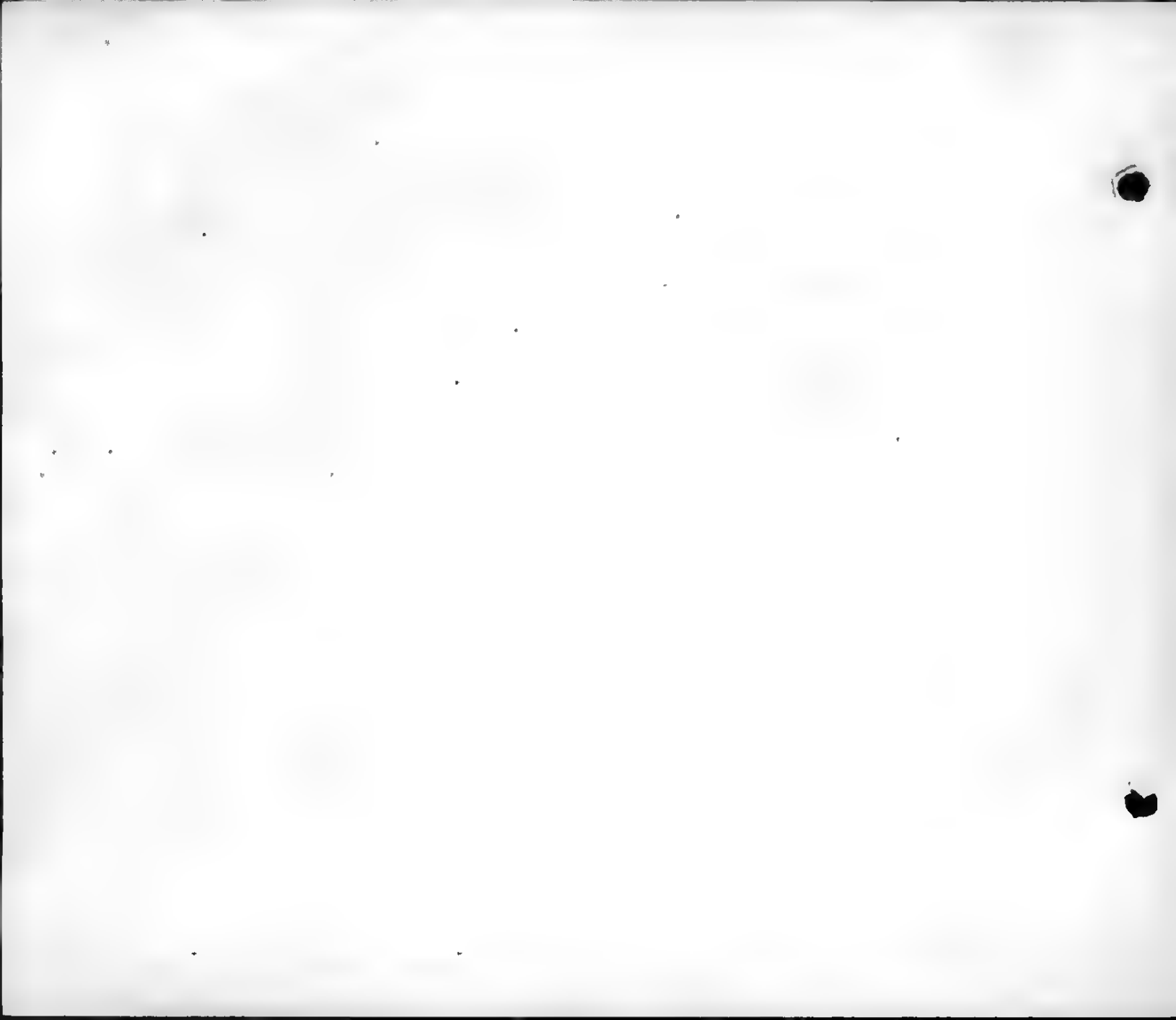
Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Baltimore</b>	MARYLAND	STATE <b>Md.</b>	COUNTY <b>Baltimore</b>
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Middle River</b>	LENGTH OF STAY OR TOWN <b>Ivy Hall Nursing Home</b>	CITY (If outside corporate limits, write RURAL and give nearest town) <b>Lodge Forest</b>	TOWN <b>X</b>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>19 Harrison St.</b>		STREET ADDRESS (If rural give location) <b>2007 Headland Rd.</b>	<b>1</b>
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <b>EDWARD</b>	(Middle) <b>F.</b>	(Last) <b>BRUN</b>	(Month) <b>June</b> (Day) <b>4</b> (Year) <b>19 55</b>
5. SEX: <b>male</b>	6. COLOR OR RACE: <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>widowed</b>	8. DATE OF BIRTH: <b>Sept. 1874</b>
9. AGE last birthday: <b>80</b> yrs.		10. AGE last birthday: <b>80</b> yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Bookkeeper</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>Wholesale Grocery</b>	
11. BIRTHPLACE (State or foreign country): <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <b>Frances Edward Brun</b>		14. MOTHER'S MAIDEN NAME: <b>Virginia Merrill</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <b>Sparrows Pt., Md.</b>		18. MEDICAL CERTIFICATION	
19. DATE OF OPERATION:		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Mar. 23 1955</b> to <b>June 3 1955</b> , that I last saw the deceased alive on <b>June 1, 1955</b> , and that death occurred at <b>8:35 AM</b> M, from the causes and on the date stated above.			
SIGNATURE <b>Joseph N. Nye</b>		ADDRESS <b>423 Eastern Ave</b> DATE SIGNED <b>June 21 6/3/55</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		24. FUNERAL DIRECTOR	
DATE REC'D BY LOCAL REGISTRAR <b>6-6-55</b>		REGISTRAR'S SIGNATURE <b>Wm. J. Dickson &amp; Sons</b>	
DATE THEREOF <b>6/7/55</b>		NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>	
LOCATION (City, town, or county) <b>Baltimore, Md.</b>		(State)	

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.



5300

## CERTIFICATE OF DEATH

Reg. Dist. No. 3/

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Baltimore</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Baltimore</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Granite</i>		LENGTH OF STAY (in this place) <i>50 years</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Granite</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) <i>Arthur</i> (Middle) <i>W.</i> (Last) <i>Butts</i>				4. DATE (Month) (Day) (Year) OF DEATH: <i>June 4 1955</i>			
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Widowed</i>	8. DATE OF BIRTH: <i>1-19-1865</i>	9. AGE last birthday: <i>90</i> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Blacksmith Tool Making</i>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <i>Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME: <i>Charles Butts</i>				14. MOTHER'S MAIDEN NAME: <i>Elizabeth Ernest</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>220-09-0379</i>		17. INFORMANT & ADDRESS: <i>Miss Emma Butts - Granite, Md.</i>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Cardiovascular Disease</i>							
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>5/25/1955</i> , to <i>6/5/1955</i> , that I last saw the deceased alive on <i>6/5/1955</i> , and that death occurred at <i>10:30 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Wm. E. Martin</i>				ADDRESS <i>M. D. Randallstown</i>		DATE SIGNED <i>6/6/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>6-7-55</i>		NAME OF CEMETERY OR CREMATORY <i>Woodlawn</i>		LOCATION (City town, or county) (State) <i>Woodlawn, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>6/6/55</i>		REGISTRAR'S SIGNATURE <i>Wm. E. Martin</i>		24. FUNERAL DIRECTOR <i>Arthur H. Hight - Hyattsville, Md.</i>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8 UNIV. A. 3

JUN 10 1957



05294

Reg. Dist.

5273

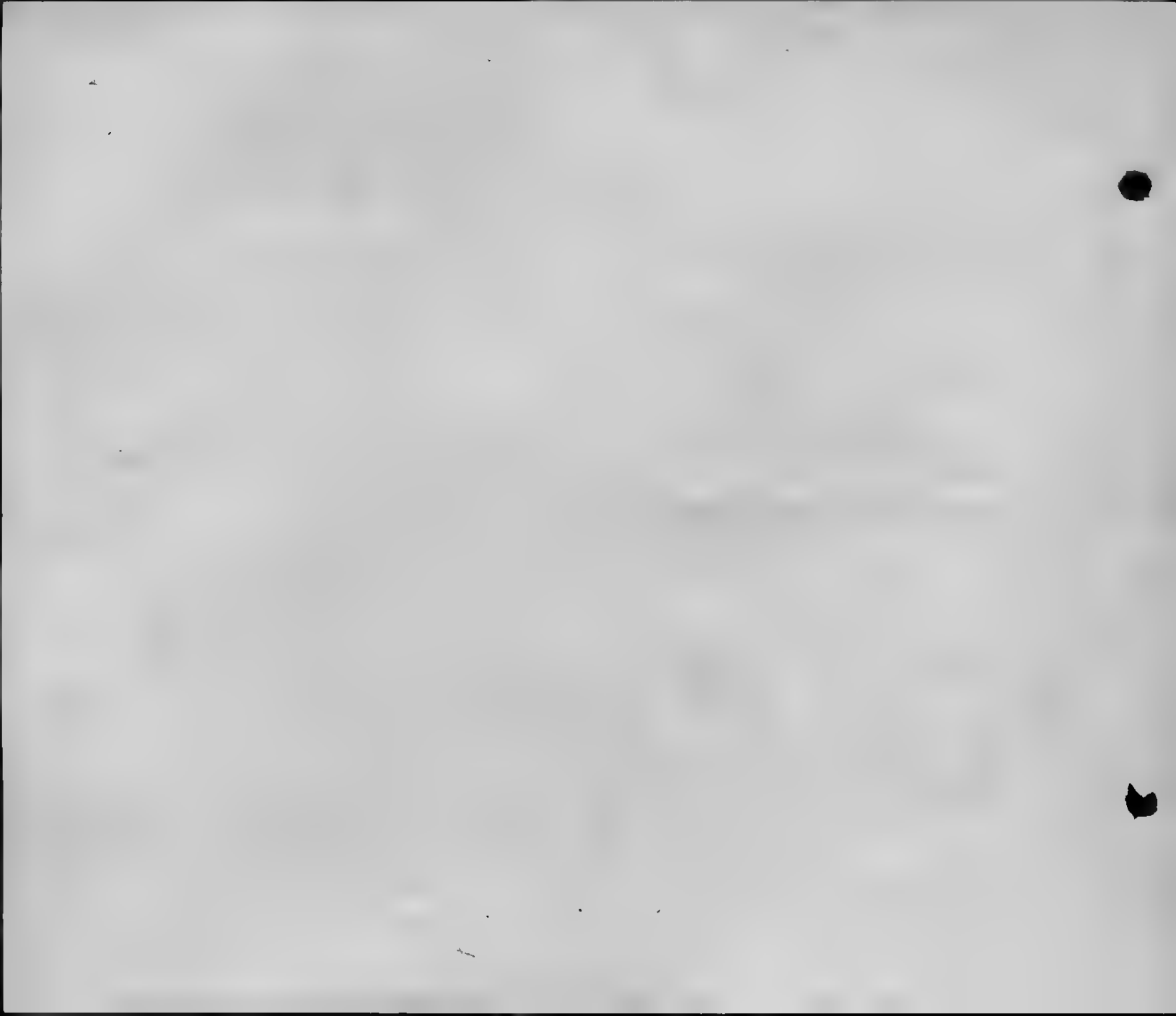
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 41

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto</u>		MARYLAND		STATE <u>md.</u>		COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 22</u>		LENGTH OF STAY (If this place) <u>55 yrs</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>Baltimore 22</u>		OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1906 48th St</u>				STREET ADDRESS (If rural, give location) <u>1906 48th Street</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) <u>John</u>		(Middle) <u>Buzgierski</u>		(Last) <u>Buzgierski</u>		Date of Death <u>June 27 1955</u>	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH: <u>4/30/1884</u>	
9. AGE last birthday: <u>71</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Laborer Box Mfg.</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>Ignatius Buzgierski</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Tadajewski</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) <u>No</u>				16. SOCIAL SECURITY No.: <u>220-05-8605</u>		17. INFORMANT & ADDRESS: <u>Mary Kuzich, 512 S. Dallas St</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Coronary occlusion</u>							
Antecedent cause(s) (b) <u>Cardiovascular disease</u>							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) <u>Death June 27 5:30 P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>M. J. Carmine M.D.</u>				DATE SIGNED <u>6/27/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>7/1/55</u>		NAME OF CEMETERY OR CREMATORY <u>Brookmont of Mary</u>		LOCATION (City or county) (State) <u>Baltimore, Md</u>	
DATE REC'D BY LOCAL REG. <u>6-30-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Charles D. Sadowski</u>		ADDRESS <u>1808 Eastern Ave.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5302

## CERTIFICATE OF DEATH

05295

Reg. Dist. No. 302

1. PLACE OF DEATH: **Baltimore**  
 County.....  
 City or town..... **Catonsville** *54*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred: *AA*  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... **Md.**..... County..... *Li*  
 City or town..... **Catonsville** *5*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. **36 Overbrook Rd.**  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3.(a) FULL NAME  
**John Broderick Callahan**

3.(b) Social Security Number

4. Sex..... **Male**  
 5. Color or race..... **W.**  
 6.(a) Single, married, widowed, or divorced..... **Widowed**  
 6.(b) Name of husband or wife..... **Dorothy Green Callahan**  
**Deceased**  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)..... **June 25, 1893**  
 8. AGE: Years..... **61** Months..... **11** Days..... **6**  
 If less than one day..... hrs. .... min.

9. Birthplace..... **Baltimore**  
 (Town, county, and state)  
 10. Usual occupation..... **Secretary**  
 11. Industry or business..... **Robert S. Green, Inc.**  
 12. Name..... **John Henry Callahan**  
 13. Birthplace..... **Baltimore, Md.**  
 14. Maiden name..... **Sarah F. McGarigle**  
 15. Birthplace..... **Baltimore, Md.**

16. Informant..... **R. William Callahan**  
 Address..... **328 Westowne Rd.**  
 17. **Burial** *June 4, 1955*  
 (Burial, cremation, or removal. Which?).....  
 Date thereof..... (month) (day) (year)  
 Cemetery or crematory..... **Woodlawn**  
 Location.....  
 18. Funeral director..... *Frank V. Cole*  
 Address..... **1913 W. Baltimore St**  
 19. *6-3* *55* *and 1/2*  
 (Date rec'd by registrar)..... Registrar

## MEDICAL CERTIFICATION

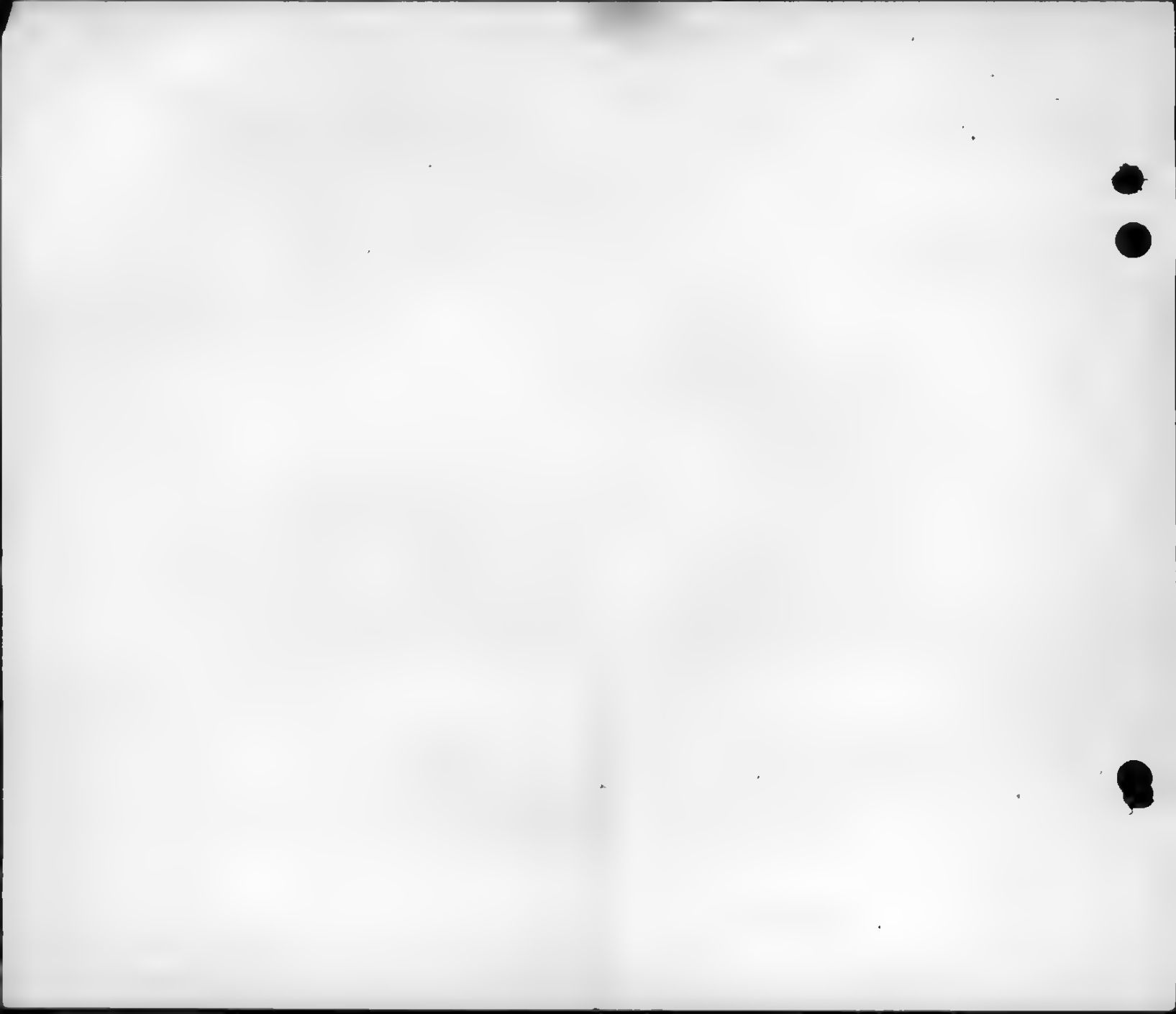
20. DATE OF DEATH..... **June 1st**..... 19 **55** at **6 P.** M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **May 18**..... 19 **54** to **June 1**..... 19 **55**  
 and that I last saw him alive on **June 1**..... 19 **55**

Immediate cause of death.....  
**Coronary Thrombosis**  
**Coronary Atherosclerosis +**  
**Myocardial insufficiency**  
 Due to.....  
 Due to.....  
 Other conditions.....  
 (Include pregnancy within 3 months of death)

DURATION  
**1 hour**  
**2 years**

Major findings of operations.....  
 Date of op.....  
 Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town)..... (County)..... (State).....  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?  
 23. SIGNATURE..... **Louis E. Vice M.D.**  
 Address..... **920 St. Paul St.**..... M. D. or other  
 Date signed..... **June 2, 55**



Reg. Dist. No. 31...

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Baltimore</b>	MARYLAND	STATE <b>Md.</b>	COUNTY <b>Baltimore</b>
CITY (If outside corporate limits, write RURAL or and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Rural Randallstown</b>	
<b>X</b> TOWN <b>Rural</b>	<b>Lifetime</b>	STREET ADDRESS (If rural give location) <b>Chapman Rd., Randallstown</b>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH: <b>June 26 1955</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS			
5. SEX: <b>Female</b>		6. COLOR OR RACE: <b>White</b>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH: <b>August 8, 1886</b>	
9. AGE last birthday <b>69</b> yrs.		10. BIRTHPLACE (State or foreign country): <b>Maryland</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Housewife</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>Augustus Reinhardt</b>		14. MOTHER'S MAIDEN NAME: <b>Elizabeth Foxwell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT & ADDRESS: <b>William A. Carter</b>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <b>170X</b>			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
20C. WHERE DID (City or town) (County) (State)		20D. HOW DID INJURY OCCUR?	
21A. TIME (Month) (Day) (Year) (Hour) OF INJURY		21B. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <b>6/11/55</b> , to <b>6/26/55</b> that I last saw the deceased alive on <b>6/26/55</b> , and that death occurred at <b>10</b> M, from the causes and on the date stated above.			
SIGNATURE <b>Wm. E. Martin</b>		ADDRESS <b>Randallstown Md</b> DATE SIGNED <b>6/27/55</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>June 29, 1955</b>	
NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		LOCATION (City, town, or county) <b>Baltimore Md.</b>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <b>6/27/55 Wm. E. Martin</b>		24. FUNERAL DIRECTOR ADDRESS <b>Samuel H. ...</b>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ROBERT A. B.

St. Louis, Mo.

1891

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

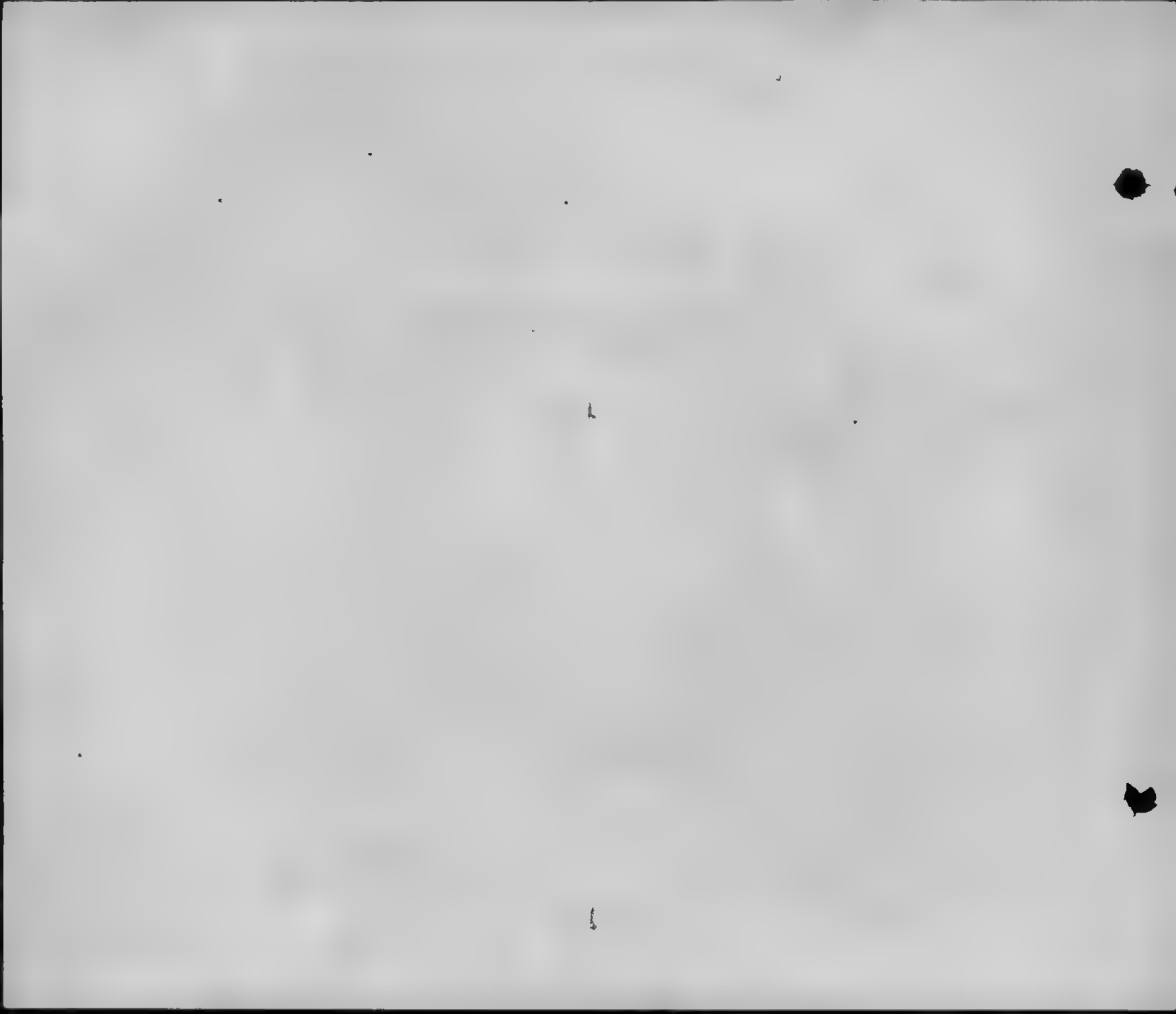
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05296  
Reg. Dist.

No. 30

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Baltimore</u>		MARYLAND	STATE <u>Md.</u>		COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN		
<u>62 TOWN Catonsville</u>		<u>1 1/2 mos.</u>	<u>Brookmount, Md.</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural, give location)		
<u>14 Spring Grove</u>			<u>6035 Broad St</u>		
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE OF DEATH (Month) (Day) (Year)		
<u>CHRIS CHRONAKER</u>			<u>June 28, 19 55</u>		
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:		9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>Aug 30, 1917</u>		<u>37</u> yrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?
<u>Carpenter</u>		<u>Building</u>	<u>New York</u>		
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
<u>Courtsaine J. Chronaker</u>			<u>Kaleati Kaukuchi</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:		
<u>Yes Army WW2</u>			<u>Hospital records</u>		

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
Immediate cause (a) <u>Strangulation by hanging</u> DUE TO Antecedent cause(s) (b) _____ Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) _____					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <u>Paranoid schizophrenia</u>					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <u>hospital</u>		21c. (City or town) (County) (State) <u>Catonsville Baltimore Md.</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>6/28/55 5:51 p M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Hung himself with sheet</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>6/29/55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>7-5-55</u>		<u>Graceland National Wash. D. C.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR	
<u>6-30-55</u>		<u>[Signature]</u>		<u>W. W. Chambers, Wash. D. C.</u>	
				ADDRESS	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

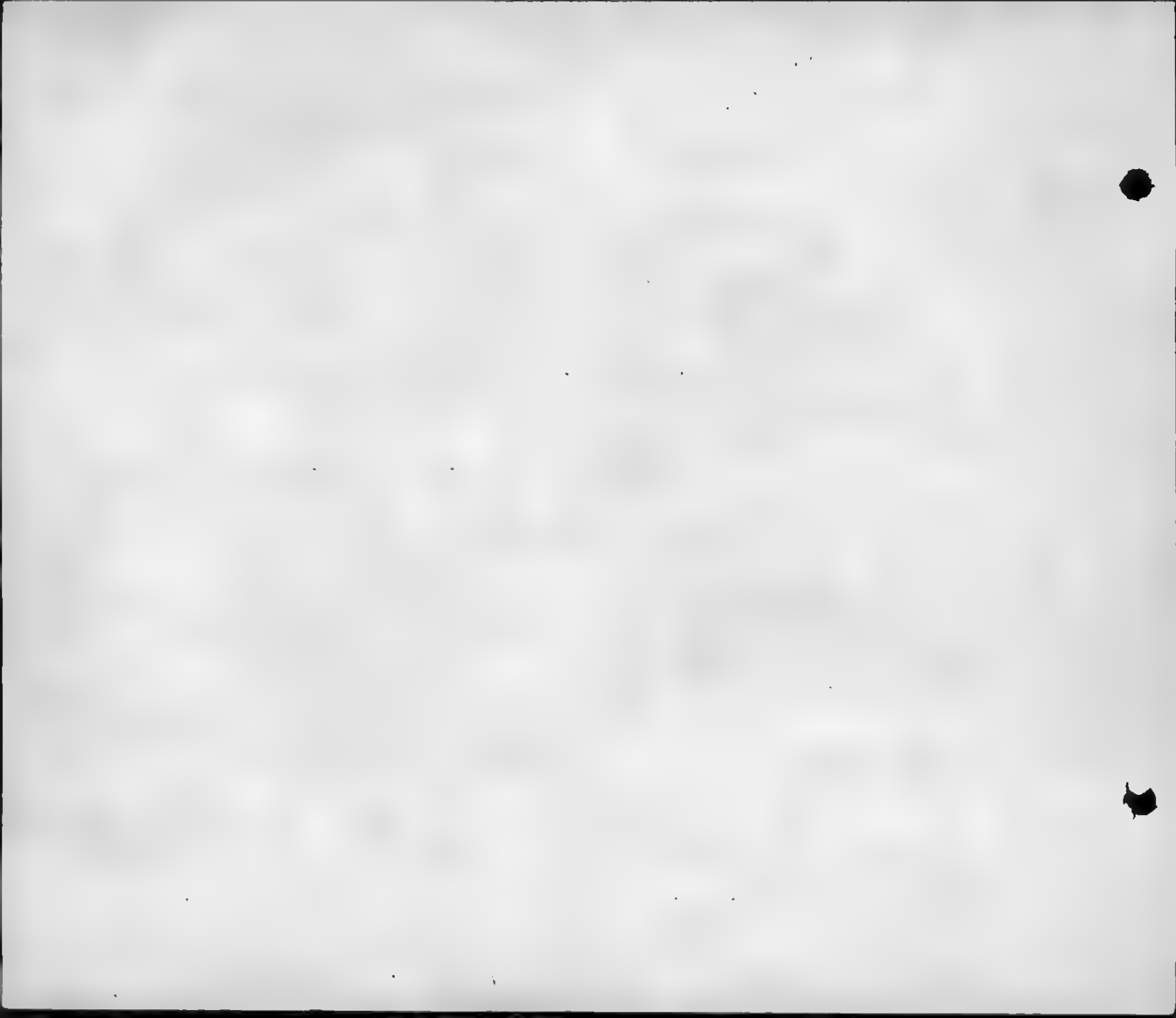
05297

5304

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>BALTIMORE</b>		MARYLAND		STATE <b>MARYLAND</b>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
TOWN <b>FORT HOWARD</b>		<b>54 DAYS</b>		TOWN <b>BALTIMORE</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>VETERANS ADMINISTRATION HOSPITAL</b>				STREET ADDRESS (If rural give location) <b>2104 PENROSE AVE.</b>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<b>LOUIS W. COLEMAN</b>				<b>June 5 1955</b>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR, Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours Min.
<b>Male</b>	<b>Colored</b>	<b>Married</b>	<b>4/14/09</b>	<b>46 yrs.</b>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<b>Laborer</b>		<b>Beth. Steel Co.</b>		<b>Spotsylvania, Virginia</b>		<b>U.S.A.</b>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<b>Luther Coleman</b>				<b>Elizabeth Diggs</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
<b>Yes WW-II</b>				<b>263 16 5607</b>			
17. INFORMANT & ADDRESS:				<b>CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MD.</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
592X IMMEDIATE CAUSE (A) <b>CHRONIC NEPHRITIS</b>						<b>Unknown</b>	
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from April 12 1955, to June 5, 1955, and that death occurred at 12:40 AM, from the causes and on the date stated above.							
SIGNED		ADDRESS		DATE SIGNED			
<b>WILLIAM B. VANDEGRIFT, M.D.</b>		<b>VAH, Fort Howard, Md.</b>		<b>6/5/55</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>6-8-55</b>		<b>Arbutus Memorial Cemetery</b>		<b>Arbutus, Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<b>6-6-55</b>		<b>George G. Nelson</b>		<b>Funeral Home</b>		<b>1348 Calhoun St. Baltimore, Md.</b>	



**5305**

**CERTIFICATE OF DEATH**

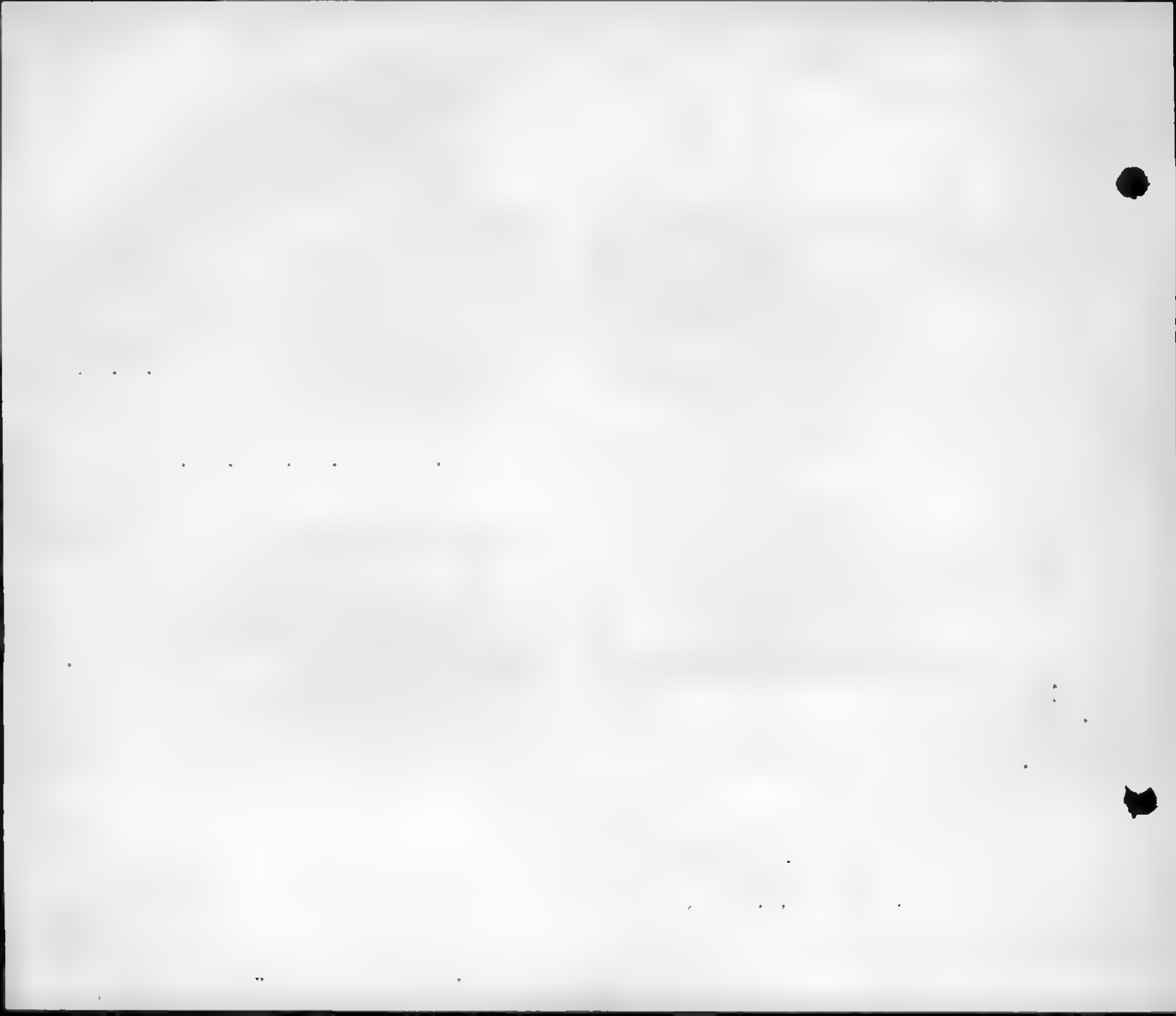
Reg. Dist. No. **4**

Item 9, Film 182 6-15-55 et

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>BALTIMORE</b>	MARYLAND	STATE <b>MARYLAND</b>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>	LENGTH OF STAY (In this place) <b>10 DAYS</b>	CITY (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	<b>3401-4</b>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>VETERANS ADMINISTRATION HOSPITAL</b>		STREET ADDRESS (If rural give location) <b>2012 E. JEFFERSON STREET</b>	
3. NAME OF DECEASED: (First) <b>GEORGE</b> (Middle) (Last) <b>COMEAX</b>		4. DATE (Month) (Day) (Year) OF DEATH: <b>JUNE 7 1955</b>	
5. SEX: <b>MALE</b>	6. COLOR OR RACE: <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>MARRIED</b>	8. DATE OF BIRTH: <b>9-22-92</b>
9. AGE last birthday: <b>63</b> yrs.		10. AGE last birthday: <b>63</b> yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>BARBER</b>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <b>E. BATON ROUGE, LOUISIANA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME: <b>CHARLES COMEAUX</b>		14. MOTHER'S MAIDEN NAME: <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give year or dates of service) <b>YES</b>		16. SOCIAL SECURITY NO: <b>Unknown</b>	
17. INFORMANT & ADDRESS: <b>CLIN.REC., VET.ADM.HOSP., FT.HOWARD, MD.</b>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <b>420.0 ARTERIOSCLEROTIC HEART DISEASE</b>		UNKNOWN	
ANTECEDENT CAUSE (B) <b>DUE TO</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <b>DUE TO</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>PNEUMONITIS, LEFT LOWER LOBE AND RIGHT LOWER LOBE</b>		Approx. 2 Wks	
19A. DATE OF OPERATION: <b>0</b>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>VA M.</b>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>MAY 28 1955</b> , to <b>JUNE 7 1955</b> , and that death occurred at <b>9:05A M.</b> from the causes and on the date stated above.			
SIGNATURE <b>F. S. Dickey</b>		DATE SIGNED <b>6-7-55</b>	
FRANCIS G. DICKEY, M.D. Chief, Medical Service		D. VAH, FORT HOWARD, MARYLAND	
23. BURIAL, CREMATION, DATE THEREOF REMOVAL (SPECIFY) <b>Burial JUNE 10, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery Baltimore, Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR <b>6-8-55</b>		24. FUNERAL DIRECTOR <b>Wm. Cook-Blight, Inc. Funeral Home 6009 Harford Rd., Baltimore 14, Md.</b>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



5306

05299

MARYLAND

STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

Baltimore Co.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>221 E. University Parkway</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>Md</u> ✓	
OR TOWN		STREET ADDRESS (If rural, give location) <u>3V01.4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>College Manor</u>			
3. NAME OF DECEASED (Type or Print)	(First) <u>George</u>	(Middle) <u>Augustus</u>	(Last) <u>Cook</u>
4. DATE OF DEATH	(Month) <u>June</u>	(Day) <u>20</u>	(Year) <u>1953</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Nov. 12, 1861</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>93</u> yrs.	11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>
12. FATHER'S NAME <u>George Augustus Cook</u>	13. MOTHER'S MAIDEN NAME <u>Elizabeth Stewarts Storck</u>	14. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>No</u>
16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS	

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## 18. MEDICAL CERTIFICATION

## INTERVAL BETWEEN ONSET AND DEATH

491X Immediate cause (a).....

chronic pneumonia3 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c).....

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Senile arteriosclerosis, carcinoma of prostate

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from May 29, 1955, to present, 1955, that I last saw the deceasedalive on Jan 17, 1955, and that death occurred at 8:15 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Ernest C. Brown Jr. M.D. 1101 W. Calvert St. Baltimore - 2 6/20/55

23. BURIAL CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>6/23/55</u>	<u>New Cathedral Cem.</u>	<u>Balto., Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>6-21-55</u>	<u>W. Hedgcock</u>	<u>Thos. J. Pickens &amp; Sons</u>	<u>Balto 17 Md.</u>	

MARGIN RESERVED FOR BINDING



# MARYLAND STATE DEPARTMENT OF HEALTH

5307

2411 N. Charles Street, Baltimore

05300

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <u>Balto. County</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>1</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Balto. County</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Balto. County</u> X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8 Fisher Road</u>		STREET ADDRESS (If rural, give location) <u>8 Fisher Road</u> 1	
3. NAME OF DECEASED (First) <u>Mary J.</u> (Middle) <u>I.</u> (Last) <u>Cook</u>		4. DATE OF DEATH (Month) <u>6</u> (Day) <u>21</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>At Home</u>	8. DATE OF BIRTH <u>Nov 12, 1887</u> 67 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	9. AGE last birthday <u>67</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John P. Law</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>John V. Cook - 8 Fisher Road</u>	
17. INFORMANT AND ADDRESS		18. MEDICAL CERTIFICATION	
4. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
199.9 Immediate cause (a) <u>Malnutrition &amp; dehydration</u>			
Antecedent cause(s) (b) <u>Generalized carcinoma metastasis</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 10, 1955</u> , to <u>June 21, 1955</u> , that I last saw the deceased alive on <u>June 21, 1955</u> , and that death occurred at <u>1:10 P.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Donald Benbow MD</u>		ADDRESS <u>2726 Calabard Ave</u> DATE SIGNED <u>June 21, 1955</u>	
23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF <u>6/24/55</u>	NAME OF CEMETERY OR CREMATORY <u>Balto. Am.</u>	LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
DATE REC'D BY LOCAL REG. <u>6-22-55</u>	REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>	24. FUNERAL DIRECTOR <u>John C. Miller Inc. - 2431 E. Chas. St.</u> ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



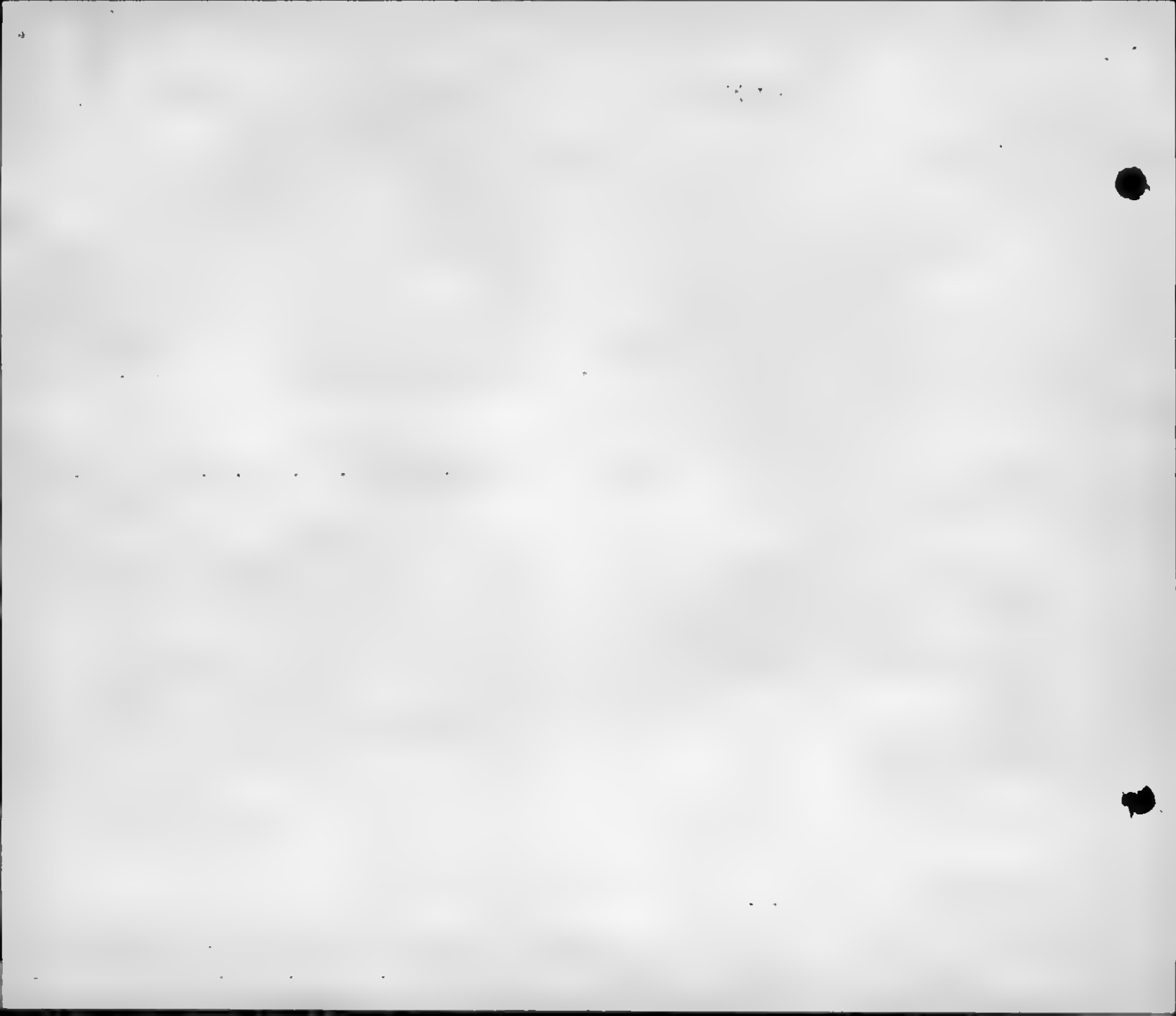
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 105301  
5308 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY	
CITY (If outside corporate limits, write RURAL, and give nearest town) <u>FORT HOWARD</u>		LENGTH OF STAY (in this place) <u>28 DAYS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VETERANS ADMINISTRATION HOSPITAL</u>		STREET ADDRESS (If rural give location) <u>921 MCKEAN AVENUE</u>					
3. NAME OF DECEASED: (First) (Middle) (Last) <u>THOMAS B. COOK</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>JUNE 1, 1955</u>			
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>COLORED</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>SINGLE</u>	8. DATE OF BIRTH: <u>1/4/88</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Transfer Co.</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>WILLIAM W. COOK</u>				14. MOTHER'S MAIDEN NAME: <u>MADDIE BOYD</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>YES</u> (If Yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>212-05-4538A</u>		17. INFORMANT & ADDRESS: <u>CLIN. REC., VET. ADM. HOSP. FT. HOWARD, MD.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>CARCINOMA OF LIVER</u>						<u>UNKNOWN</u>	
ANTECEDENT CAUSE (B) <u>DUE TO</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>VA</u> M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 4</u> , 19 <u>55</u> to <u>June 1</u> , 19 <u>55</u> , and that death occurred at <u>6:00 AM</u> , from the causes and on the date stated above. SIGNATURE <u>Francis G. Dickey</u> ADDRESS <u>VAH, FORT HOWARD, MARYLAND</u> DATE SIGNED <u>6-1-55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6-6-55</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6-6-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Charles G. Cooper</u>		ADDRESS <u>512 N. Carrollton Ave. Baltimore, Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





ROYALTY A. J.

1955

1955

5310

## CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Balto.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Owings Mills</u>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Park Heights Ave., - Ext'd</u>		STREET ADDRESS (If rural give location) <u>Park Heights Ave., Extd</u>	1
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>CHRISTOPHER K. DEMENT</u>		DATE OF DEATH: <u>June 23, 1955</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>April 6, 1876</u>
9. AGE last birthday: <u>79</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>N. C.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Artist</u>		12. CITIZEN OF WHAT COUNTRY? <u>Commercial</u>	
13. FATHER'S NAME: <u>Alphonsus Dement</u>		14. MOTHER'S MAIDEN NAME: <u>Lucretia Plesants</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS: <u>Cwings Mills, Md. Mrs. Mattie H. Dement-Park Hgts Ave.-Ex</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>		<u>34 hours</u>	
ANTECEDENT CAUSE (B) <u>Coronary Sclerosis</u>		<u>1 yr</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>Hrt. Sclerosis</u>		<u>2-3 yrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 16<sup>th</sup>, 1955</u> , to <u>June 23<sup>rd</sup>, 1955</u> , that I last saw the deceased alive on <u>June 23<sup>rd</sup>, 1955</u> , and that death occurred at <u>10 A M.</u> from the causes and on the date stated above.			
SIGNATURE <u>James A. Dement</u>		M. D. <u>Pikesville, Md.</u> DATE SIGNED <u>6/23/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/25/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Parkwood Cem.</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6-24-55</u>		REGISTRAR'S SIGNATURE <u>D. J. Dement</u>	
FUNERAL DIRECTOR'S SIGNATURE <u>Chas. J. Pikesville &amp; Sons</u>		ADDRESS <u>17</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



5311

## CERTIFICATE OF DEATH

Reg. Dist., No.

30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
52 TOWN <u>St. Louisville</u>	9 days	Newport	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
14 Spring Grove State Hospital			
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(Type or Print)	(First) (Middle) (Last)	OF DEATH: 6-27-1955	
LMORY	JOSEPH		
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:
Male	White	Married	Unknown
9. AGE last birthday		IF UNDER 1 YEAR	IF UNDER 24 HRS.
109 yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):
Unknown			Unknown
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
Unknown		Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
Unknown		Unknown	
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION	
Records Spring Grove State Hospital		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
422,1			
IMMEDIATE CAUSE (A)		Cerebrovascular accident	
ANTECEDENT CAUSE (S)		DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) Anteriorcerebral cardiovascular	
		DUE TO	
		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED	
OF INJURY		While <input type="checkbox"/> Not while <input type="checkbox"/>	
		at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 6-18-1955 to 6-27-1955 that I last saw the deceased alive on 6-27-1955, and that death occurred at 9:25 M. from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
S. Wachler		6-27-55	
Stella Wachler		M. D. Carrollville 25 Maryland	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
Burial		Dentsville Md	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR	
6/30/55		Hunt & Ryan	
REGISTRAR'S SIGNATURE		ADDRESS	
Julius H. Ryan		Waldorf Md	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U. S. DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5312

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05305  
Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Stonleigh</u>				TOWN <u>Stonleigh</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7110 Rich Hill Road</u>				STREET ADDRESS (If rural, give location) <u>7110 Rich Hill Road</u> /			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH		(Month) (Day) (Year)			
DAVID DE ROCHE		6		29		19 55	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White		April 3, 1873	82 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>grocery merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Crawford Co. Ohio</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>John L. DeRoche</u>				14. MOTHER'S MAIDEN NAME: <u>Da</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No.: <u>275-01-0622</u>		17. INFORMANT & ADDRESS: <u>Daryl R. DeRoche 7110 Rich Hill Road</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>976X</u> Immediate cause (a)..... <u>Gunshot wound of head</u> DUE TO Antecedent cause(s) (b)..... Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c).....							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>2</u>		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <u>home</u>		21c. (City or town) (County) (State)			
<u>Stonleigh</u> <u>Baltimore</u> <u>Maryland</u>							
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Shot self in head</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>William J. DeRoche</u>		M. D. <u>6/30/55</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		DATE THEREOF <u>6-30-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Union</u>		LOCATION (City, town, or county) (State) <u>Columbus Ohio</u>	
DATE REC'D BY LOCAL REG. <u>June 30, 1955</u>		REGISTRAR'S SIGNATURE <u>Mabel C. Gray</u>		24. FUNERAL DIRECTOR <u>John Burns Sons - 40 York Rd</u>		ADDRESS <u>Yorson 4</u>	



5313

## MARYLAND STATE DEPARTMENT OF HEALTH

05306

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Towson</u> <u>Baltimore</u> <u>3014</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mercy Villa 6400 Bellona Ave</u>		STREET ADDRESS (If rural, give location) <u>1120 Greenmount Ave</u> ✓	
3. NAME OF DECEASED (Type or Print)	(First) <u>Mary</u>	(Middle) <u>C</u>	(Last) <u>Devon</u>
4. DATE OF DEATH	(Month) <u>June</u>	(Day) <u>1</u>	(Year) <u>1955</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Nov. 1, 1874</u>
9. AGE last birthday <u>80</u> yrs.		10. If under 1 year: Months <u>8</u> Days <u>1</u> Hours <u>19</u> Mins. <u>55</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Lawrence Devon</u>		14. MOTHER'S MAIDEN NAME <u>Mary Callan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Jane S. Holt</u>		<u>1120 Greenmount Ave</u>	

## 18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <u>Cerebral Hemorrhage</u>		<u>8 days</u>
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		<u>5 years</u>
(c) <u>Arteriosclerotic Cardio-Vascular Disease</u>		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
---	--

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
------------------------	----------------------------------	--

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE P. H. Lynn Physician 11 East Chase St. #2 DATE SIGNED 6/2/55

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>June 1, 1955</u>	<u>Cathedral Cemetery</u>	<u>Baltimore, Maryland</u>	

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>June 3, 1955</u>	<u>A. W. Hedrich</u>	<u>H. N. Weaver Son 18057 Calvert St</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

A5307

5314

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>1</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Owensboro</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>101 Kolb Avenue</u>		STREET ADDRESS <u>101 Kolb Avenue</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>August</u> (First) (Middle) (Last) <u>Ditzel</u>		4. DATE OF DEATH <u>June 14</u> (Month) (Day) (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept 8, 1878</u>
9. AGE last birthday <u>76</u> yrs.		10. If under 1 year: Months <u>14</u> Days <u>19</u> Hours <u>55</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>United States</u>	
13. FATHER'S NAME <u>Charles Ditzel</u>		14. MOTHER'S MAIDEN NAME <u>Florintine Wisterfelt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-03-8491</u>	
17. INFORMANT AND ADDRESS <u>Mrs Flora Ditzel 101 Kolb Avenue</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

321X Immediate cause (a) \_\_\_\_\_  
Antecedent cause(s) (b) \_\_\_\_\_  
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) \_\_\_\_\_

Cerebral hemorrhage  
arterio-sclerosis

INTERVAL BETWEEN ONSET AND DEATH

2 hrs12 hrsII. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) SUICIDE PLACE (Home, farm, factory, street, office bldg., etc.) INJURY  
TIME (Month) (Day) (Year) (Hour) 11:15 INJURY OCCURRED While at Work ☐ Not While ☐ At work ☐

20. AUTOPSY? Yes ☐ No ☐

HOW DID INJURY OCCUR?

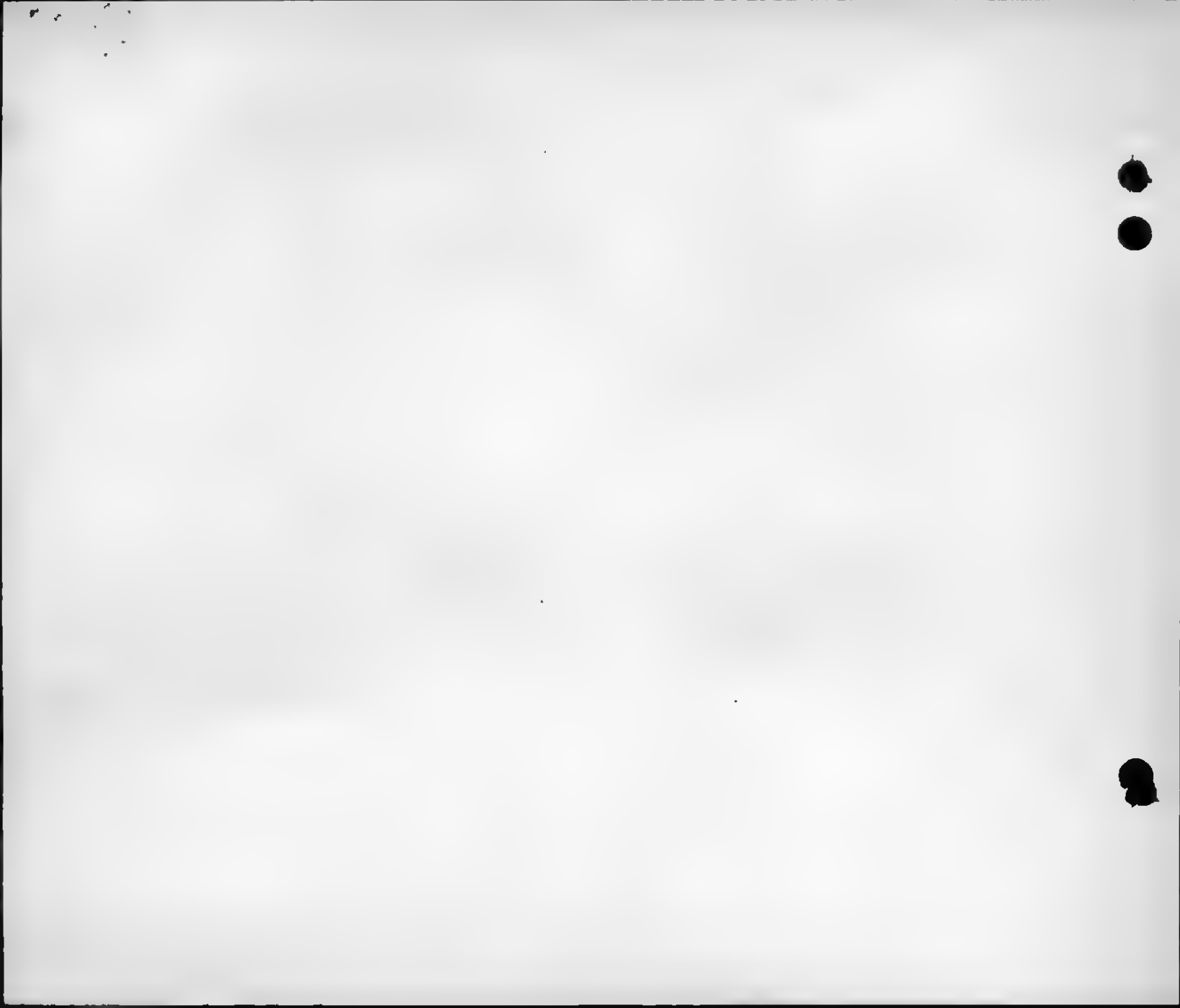
22. I hereby certify that I attended the deceased from June 14, 1955, to June 14, 1955, that I last saw the deceased alive on June 14, 1955, and that death occurred at 1 P.m., from the causes and on the date stated above.  
SIGNATURE [Signature] (Degree or title) ADDRESS [Address] DATE SIGNED 6-15-55

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE THEREOF June 18, 1955 NAME OF CEMETERY OR CREMATORY Moreland Memorial Park LOCATION (City, town, or county) Baltimore, Maryland (State) Md  
DATE REC'D BY LOCAL REG. 6-15-55 REGISTRAR'S SIGNATURE [Signature] 24. FUNERAL DIRECTOR Lilly & Zeiler Inc., 403 S. Wolfe St. ADDRESS [Address]

MARGIN RESERVED FOR BILLING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

05309

Reg. Dist. No. 30

5315

1. PLACE OF DEATH COUNTY <b>Baltimore</b> CITY (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville rural</b> HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Dillion Heights</b>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b> COUNTY <b>Baltimore</b> CITY (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville rural</b> STREET ADDRESS (If rural, give location) <b>Dillion Heights</b>	
3. NAME OF DECEASED (Type or Print) <b>CATHERINE ANNA DORSCH</b>		4. DATE OF DEATH (Month) <b>6</b> (Day) <b>23</b> (Year) <b>1955</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>8-5-1885</b>
9. AGE last birthday <b>69</b> yrs. If under 1 year Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John Wittman</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Haunsteine</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY No. <b>None</b>	
17. INFORMANT AND ADDRESS <b>Frank Dorsch, Catonsville, Md</b>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

581.0 Immediate cause (a) <b>Cirrhosis of the liver</b>	INTERVAL BETWEEN ONSET AND DEATH <b>1 yr +</b>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) _____	
(c) _____	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	<b>Adenocarcinoma of sigmoid with metastases</b>	<b>1 yr +</b>
---	--	---------------

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **18 June**, 19**55**, to **23 June**, 19**55**, that I last saw the deceased alive on **23 June**, 19**55**, and that death occurred at **7:15 p.m.**, from the causes and on the date stated above.

SIGNATURE **John H. Heston, Jr. M.D.** (Degree or title) ADDRESS **1118 N. Paul St., Balt. 2, Md** DATE SIGNED **6-24-55**

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<b>Burial</b>	<b>6-27-55</b>	<b>St. Johns Lutheran</b>	<b>Pfieffers Corner</b>	<b>Md</b>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<b>16-6-55</b>	<b>George W. Laumann</b>	<b>F.C. Eginbotham</b>	<b>Ellicott City, Md.</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1953 10  
5316 CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH: <i>Baltimore</i>				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Harmon</i>		MARYLAND		STATE <i>md.</i> COUNTY <i>Baltimore</i>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Essey</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Essey</i>		54	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) <i>307 Taylor Ave.</i>			
3. NAME OF DECEASED: (First) (Middle) (Last) <i>CHARLES FRED. DOSCH</i>				4. DATE OF DEATH: (Month) (Day) (Year) <i>JUNE 4 - 1955</i>			
5. SEX: <i>MALE</i>	6. COLOR OR RACE: <i>WHITE</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH: <i>DEC. 11 - 1892</i>	9. AGE last birthday: <i>62</i> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Order Grain Elevator</i>				10b. KIND OF BUSINESS OR INDUSTRY: <i>Baltimore</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <i>John R. Dosch</i>				14. MOTHER'S MAIDEN NAME: <i>Martha Krister</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <i>213-05-0638</i>		17. INFORMANT & ADDRESS: <i>Lothie Dosch (Wife) Above</i>			

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			
Immediate cause (a) <i>151X Carcinoma of Stomach</i>			<i>2 yrs</i>
DUE TO			
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last			
(c)			

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION:	
		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
SUICIDE HOMICIDE		INJURY			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from *March 1954* to *June 4, 1955*, that I last saw the deceased alive on *June 4, 1955*, and that death occurred at *9:43 PM*, from the causes and on the date stated above.

SIGNATURE *J. M. Dosch MD* (DEGREE OR TITLE) ADDRESS *423 Eastern Ave. Essey* DATE SIGNED *6/6/55*

23. BURIAL, CREMATION REMOVAL (Specify): <i>Burial</i>	DATE THEREOF: <i>June 8 - 55</i>	NAME OF CEMETERY OR CREMATORY: <i>Oak Lawn</i>	LOCATION (City, town, or county) (State): <i>Essey Md.</i>
DATE REC'D BY LOCAL REG. <i>6-7-55</i>		REGISTRAR'S SIGNATURE: <i>John S. Connelly</i>	24. FUNERAL DIRECTOR ADDRESS: <i>Essey</i>



5317

## CERTIFICATE OF DEATH

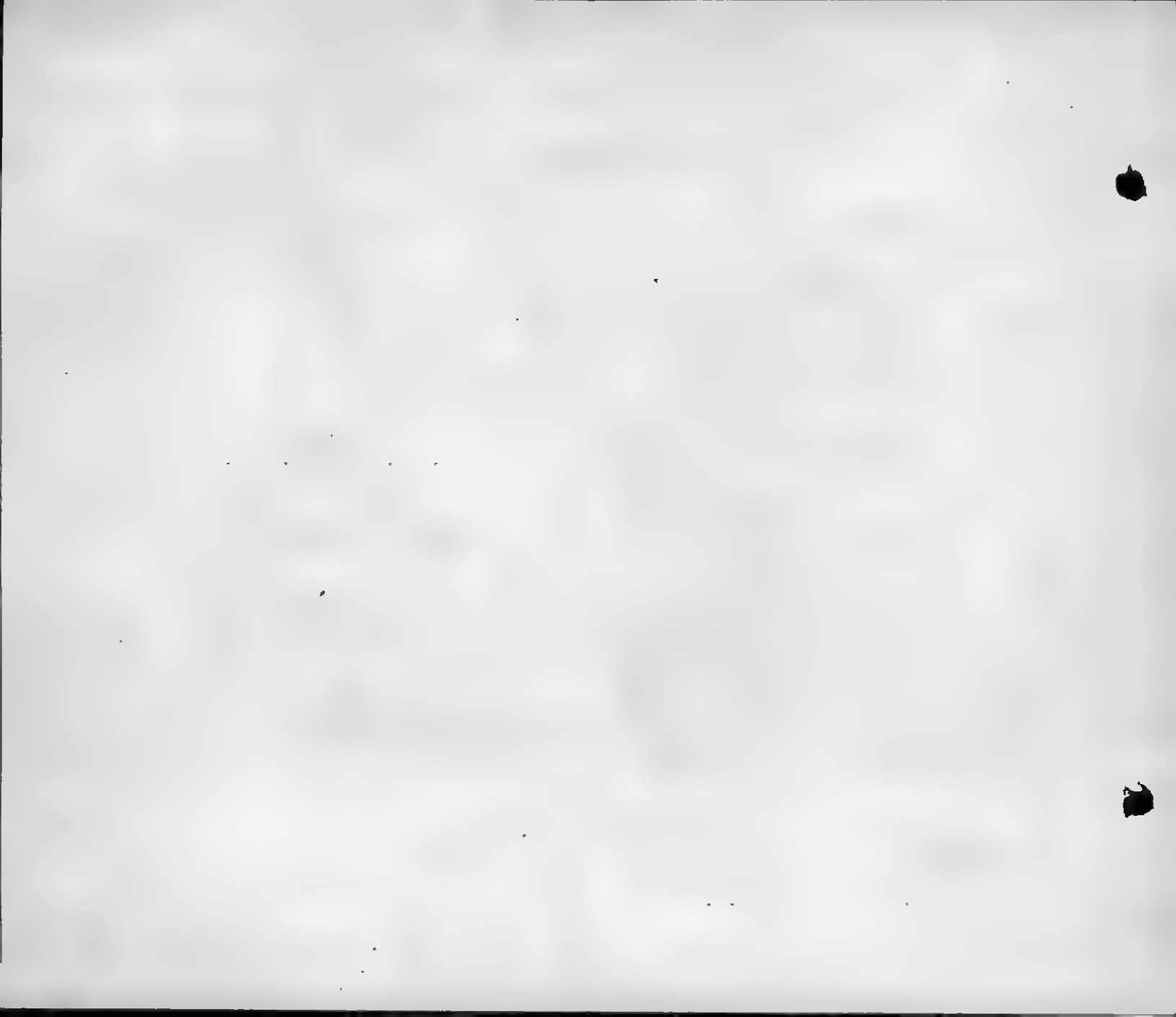
Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>FORT HOWARD</u>		LENGTH OF STAY (in this place) <u>98 DAYS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTIMORE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VETERANS ADMINISTRATION HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>730 KIRSCH COURT</u>			
3. NAME OF DECEASED: (First) <u>EDWARD</u> (Middle) <u>W.</u> (Last) <u>DRIVER</u>				4. DATE (Month) (Day) (Year) OF DEATH. <u>JUNE 1 1955</u>			
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>COLORED</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>2-14-94</u>	9. AGE last birthday <u>61</u> yrs.	IF UNDER 1 YEAR: Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>LABORER</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>BREWERY</u>		11. BIRTHPLACE (State or foreign country): <u>BALTIMORE, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>JERRY B. DRIVER</u>				14. MOTHER'S MAIDEN NAME: <u>LILLY BARNES</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service) <u>YES WW I</u>				16. SOCIAL SECURITY NO. <u>213-26-1350</u>		17. INFORMANT & ADDRESS: <u>CLIN.REC., VET.ADM.HOSP., FT.HOWARD, MD.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>150x CARCINOMA OF ESOPHAGUS</u>						1 YEAR	
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from FEB. 23, 1955, to JUNE 1, 1955, that I last saw the deceased <u>alive on</u> and that death occurred at <u>10:15M</u> , from the causes and on the date stated above.							
SIGNATURE <u>WILLIAM B. VANDEGRIET, M.D.</u>				ADDRESS <u>M. D. VAH, FORT HOWARD, MARYLAND</u> DATE SIGNED <u>6-2-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6-6-55</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6-3-55</u>		REGISTRAR'S SIGNATURE <u>W. B. Vandegriet</u>		24. FUNERAL DIRECTOR <u>Arlington S. Phillips, 1808 N. Monroe St. Baltimore 17, Maryland</u>			

MARGIN RESERVE FOR BINNING

VS. A15--10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



5318

## CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH:		2. USUAL RESIDENCE, (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural - Freeland</u>	LENGTH OF STAY (in this place) <u>30 yrs.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural - Freeland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Beckleysville Rd</u>		STREET ADDRESS (If rural give location) <u>Beckleysville Rd</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>J.</u>	(Middle) <u>Kelley</u>	(Last) <u>Duncan</u>	(Month) <u>June</u> (Day) <u>14</u> (Year) <u>1955</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Oct. 16, 1870</u>
9. AGE last birthday <u>84</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
11. BIRTHPLACE (State or foreign country): <u>Norrisville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME: <u>Frank Duncan</u>		14. MOTHER'S MAIDEN NAME: <u>Elizabeth Bell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Glady's Rutz</u>	
17. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Pulmonary Embolus</u>		<u>6 hrs</u>	
ANTECEDENT CAUSE (B) <u>Hypertrophic Cystitis</u>		<u>6 months</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) <u>Prostatitis</u>		<u>10 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>5-19-55</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Stellate Urinary Calculus - Hypertostatism</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11-19-55</u> , to <u>June 14, 1955</u> , that I last saw the deceased alive on <u>6-13</u> , 19 <u>55</u> , and that death occurred at <u>5:50 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>James H. Mullan</u>		DATE SIGNED <u>6-15-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 17, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Stewartstown Cemetery</u>		LOCATION (City, town, or county) (State) <u>Stewartstown, York Co., Pa</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6/16/55</u>		24. FUNERAL DIRECTOR <u>Jacob Gartenstein</u>	
REGISTRAR'S SIGNATURE <u>Christina L. Buxton</u>		ADDRESS <u>New Freedom, Pa.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JUN

1951

BIRMINGHAM A 8

5319

05313

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist.

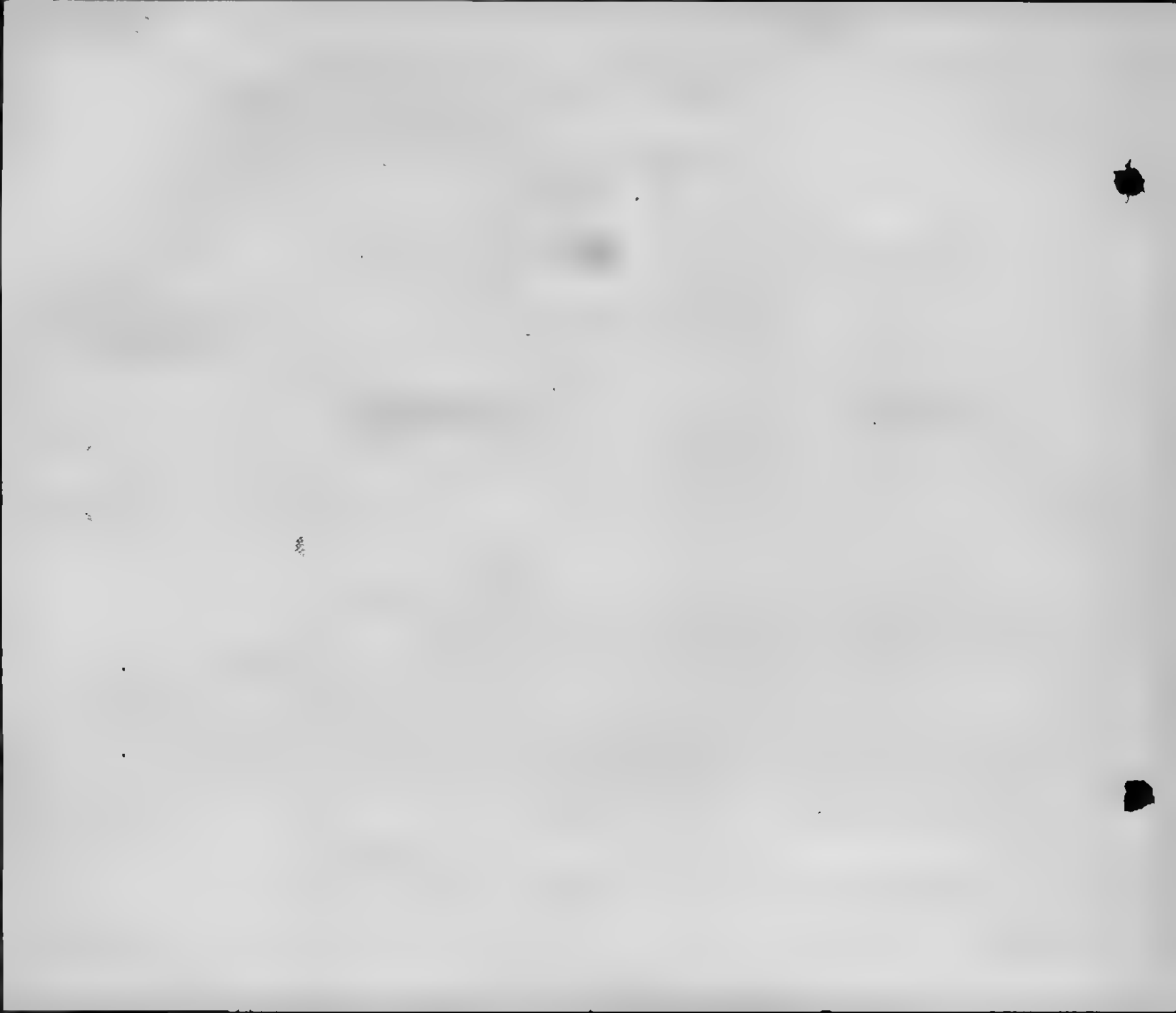
No. ....

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Baltimore</u>	MARYLAND		STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)	CITY (If outside corporate limits write RURAL and give nearest town)		
<u>52 TOWN Baltimore</u>		<u>360. 12 days</u>	<u>51 TOWN Baltimore</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring House State Hospital</u>			STREET ADDRESS (If rural, give location) <u>5722 River Road</u>		
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE OF DEATH (Month) (Day) (Year)		
<u>Peter</u> <u>Dunn</u>			<u>6-30-1955</u>		
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>6-11-1873</u>		9. AGE last birthday: <u>81</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Foreman machine shop</u>		10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME: <u>William E. Dunn</u>			14. MOTHER'S MAIDEN NAME: <u>Margaret Frey</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>Unkn</u>	17. INFORMANT & ADDRESS: <u>Records Spring House St</u>		

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				<u>2. 12. 3</u>	
<u>423.0</u>					
Immediate cause (a) <u>Cardio pulmonary thrombosis</u>				<u>2. 12. 3</u>	
DUE TO					
Antecedent cause(s) (b) <u>Infective mononucleosis</u>				<u>2. 12. 3</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE					
stating underlying cause last (c) <u>Arteriosclerotic heart disease</u>				<u>Years</u>	
II/OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Fracture of neck of right femur</u>				<u>1 mo. 12 days</u>	
19a. DATE OF OPERATION: <u>7-1-55</u>		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) <u>Home</u>		21c. (City or town) (County) (State) <u>Baltimore Baltimore Md.</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>7-1-55</u> M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Pushed down by another patient</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE: <u>William K. Gallagher</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7-1-55</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>7-4-55</u>		NAME OF CEMETERY OR CREMATORY: <u>Baltimore</u>	
DATE REC'D BY LOCAL REG. <u>7-5-55</u>		REGISTRAR'S SIGNATURE: <u>W. H. Hedrick</u>		24. FUNERAL DIRECTOR: <u>Frank A. Cole</u>	
				ADDRESS: <u>1913 W. Balto. St.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

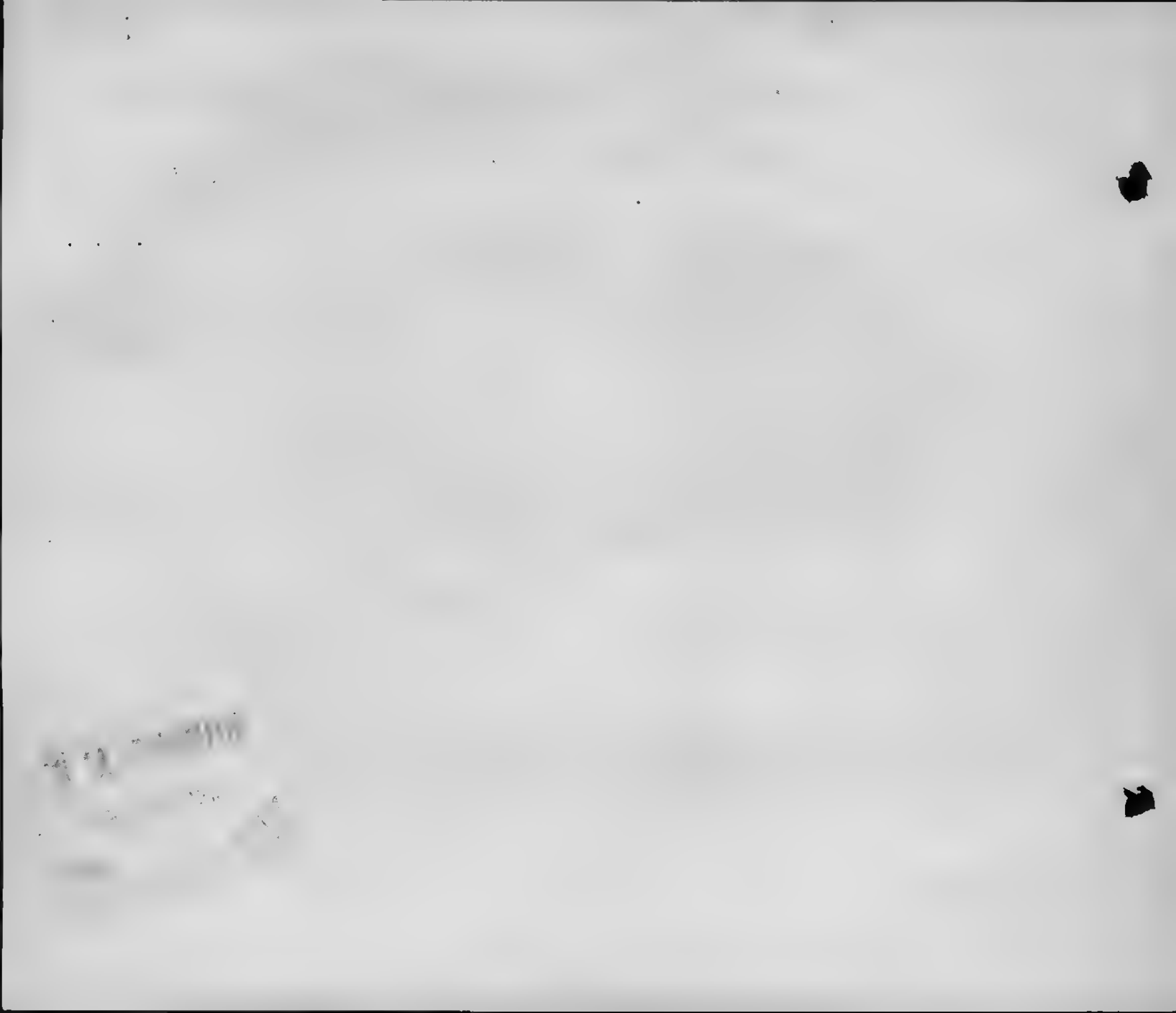
# 5320

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05314  
Reg. Dist. No. ....

<b>1. PLACE OF DEATH:</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b>			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Prince George</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Catonsville</u>		LENGTH OF STAY (In this place) <u>9mo. 12 days</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Washington</u>		<u>16x2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hos</u>				STREET ADDRESS (If rural, give location) <u>1222 Rhode I. Lane Ave.</u>			
3. NAME OF DECEASED: (First) <u>Roberts</u> (Middle) <u>C.</u> (Last) <u>Duvall</u>		4. DATE OF DEATH <u>June 14</u> , 19 <u>55</u>					
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>1-2-1874</u>	9. AGE last birthday: <u>81</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>brewer</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>John Taylor</u>				14. MOTHER'S MAIDEN NAME: <u>Elizabeth Taylor</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>Union</u>		17. INFORMANT & ADDRESS: <u>Records Spring Grove State</u>			
<b>18. MEDICAL CERTIFICATION</b>						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>902.7</u> <u>Inanition and</u> DUE TO							
Antecedent cause(s) (b) <u>Senile Brain Disease</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>MURDER and Generalized Senility</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>fracture of left femur</u>							
19a. DATE OF OPERATION: <u>5-3-55</u>		19b. MAJOR FINDING OF OPERATION: <u>Fractured femur was pin b. Steinman pin</u>				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <u>hospital</u>		21c. (City or town) (County) (State) <u>Catonsville Baltimore Maryland</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>4-26-55</u> M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fell to floor while trying to get</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Herb M. Kieffer</u>		1010 Keede on		CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER M. D. ASSISTANT MEDICAL EXAM.		DATE SIGNED <u>6-15-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>6-18-55</u>		NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
DATE REC'D BY LOCAL REG. <u>6-15-55</u>		REGISTRAR'S SIGNATURE <u>T. E. Harris</u>		24. FUNERAL DIRECTOR <u>W. W. Chambers Co. 1400 Chapin N.W.</u>		ADDRESS <u>4</u>	



5321

## CERTIFICATE OF DEATH

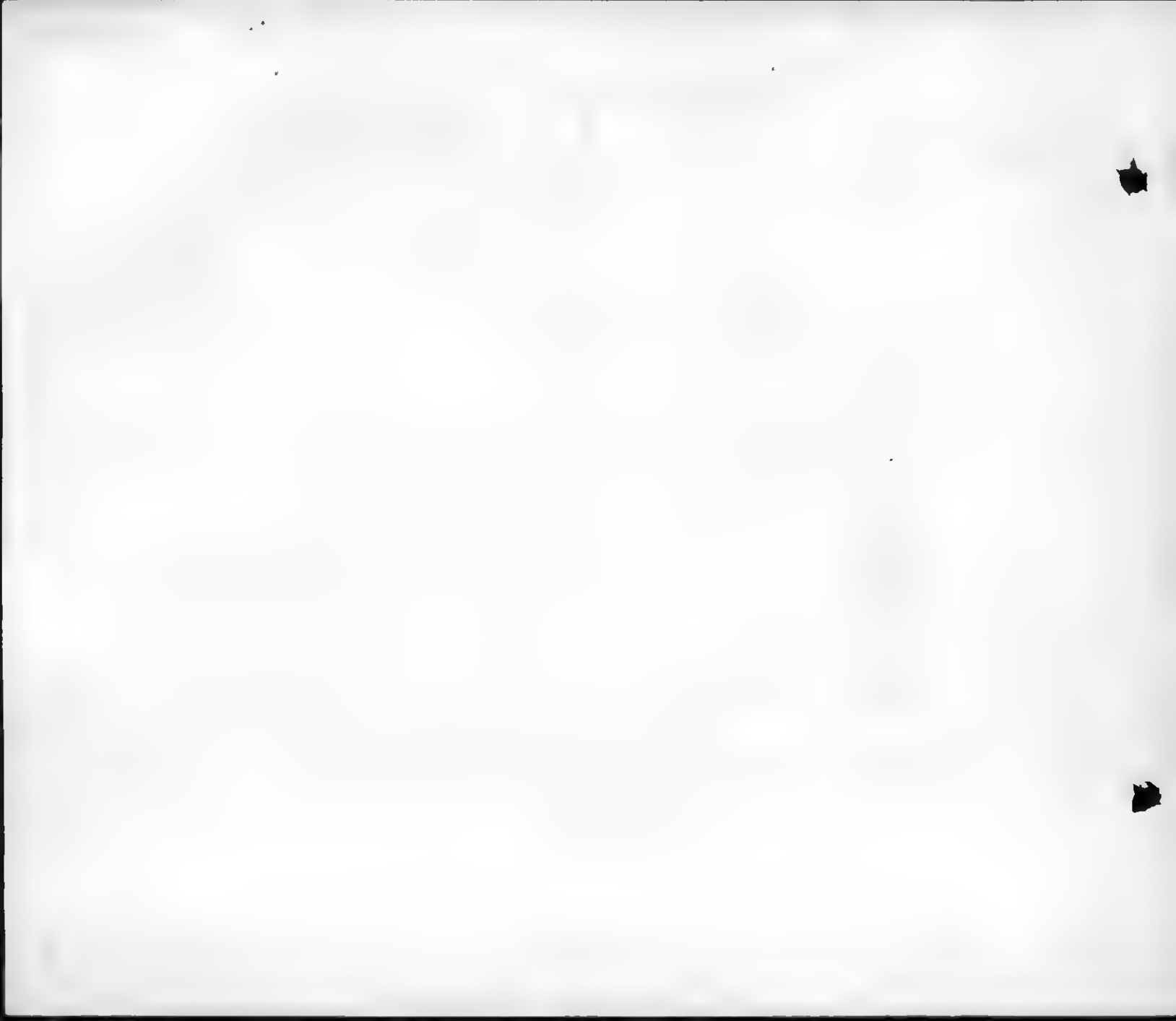
Reg. Dist. No.

32

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Pikesville</u>		<u>6 yrs</u>		OR TOWN <u>Pikesville</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>705 Milford Mill Rd</u>				STREET ADDRESS (If rural give location) <u>705 Milford Mill</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
OF DEATH: <u>Cora Olga Einwaechter</u>				OF DEATH: <u>June 29 1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH: <u>6 Oct 1876</u>	
9. AGE last birthday: <u>78</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>none</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME: <u>Henry Ruhl</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Kratz</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>1920</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS: <u>Mrs. Fred Einwaechter, 905 Milford Mill Rd, Pikesville, Md</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Hypertensive cardiovascular disease.</u>						<u>8 yrs</u>	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21B. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from ....., 1950, to <u>29 June, 1955</u> , that I last saw the deceased alive on <u>29 June, 1955</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Paul H. Royce</u>				ADDRESS <u>Pikesville 8 md</u>		DATE SIGNED <u>29 June 55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		<u>7/2/55</u>		Loudon Park Cemetery		Baltimore, Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>31-55</u>		<u>W.D. Hedrick</u>		<u>Wm. J. Tichenor &amp; Sons - North &amp; Pa. aces.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5322

MARYLAND STATE DEPARTMENT OF HEALTH

05316

# CERTIFICATE OF DEATH FOR MEDICAL EXAMINERS

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2928 Northwind Rd</u>		STREET ADDRESS (If rural, give location) <u>2823 Erie Ave Balto 34</u>	
3. NAME OF DECEASED (Type or Print) <u>Elizabeth Kennedy</u>		4. DATE OF DEATH <u>June 12 1955</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>June 9-1882</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto City md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Chas A Sefton</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Kennedy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>Mrs Harry Torbit 2823 Erie Ave</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a) <u>Coronary Occlusion</u>		Sudden	
Antecedent cause(s) (b) <u>Hypertension</u>		8 yrs.	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>U</u>		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH		PLACE (Home, farm, factory, street, or office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
22. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes, accident, suicide, homicide, undetermined.			
SIGNATURE <u>Charles F. Donnell MD</u>		DATE SIGNED <u>June 14, 1955</u>	
DEGREE OR TITLE <u>MD</u>		ADDRESS <u>7501 Yacht Rd Towson 4 md 6/15/55</u>	
23. CREMATION (Specify) <u>Burial</u>		DATE THEREOF <u>6/15/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Morland Men Can</u>		LOCATION (City, town, or county) (State) <u>Balto md</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>June 14, 1955 U. W. Heddy</u>		24. FUNERAL DIRECTOR <u>Lassalle Funeral Home</u>	
ADDRESS <u>7401 Belair Rd</u>			

11111

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5323

CERTIFICATE OF DEATH

Reg. Dist. No. 31

05317

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u> Md. </u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2124 Southland Rd.</u>				STREET ADDRESS (If rural give location) <u>2124 Southland Rd.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <u>June 29 19 55</u>			
<u>Vincent Joseph Fava</u>							
5. SEX. <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Nov. 29, 1899</u>	9. AGE last birthday: <u>55</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY: <u>Turst Co.</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Salvatore Fava</u>		14. MOTHER'S MAIDEN NAME: <u>Mary A. Tamburo</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>Yes</u> (If Yes, give war or dates of service): <u>WW2</u>		16. SOCIAL SECURITY NO.: <u>217-22-7368</u>	
17. INFORMANT & ADDRESS: <u>Theresa M. Fava - 2124 Southland Rd.</u>		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE: <u>420.1</u>		(A) <u>Adren. P. H. Syndrome</u>		<u>2 days</u>			
ANTECEDENT CAUSE (S):		DUE TO					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST		(B) <u>Congestive Heart Failure</u>		<u>5 weeks</u>			
		DUE TO					
		(C) <u>Coronary Thrombosis</u>		<u>1 1/2 months</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>June 29, 1955</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 10, 1953</u> , to <u>June 29, 1955</u> , that I last saw the deceased alive on <u>June 28</u> , 1955, and that death occurred at <u>5:05 AM</u> , from the causes and on the date stated above.		SIGNATURE <u>Edwin Y. Simpson</u>		ADDRESS <u>8204 Gladys Rd, Balt 7, Md</u>		DATE SIGNED <u>6/29/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 2, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6-30-55</u>		REGISTRAR'S SIGNATURE <u>Edwin Y. Simpson</u>		24. FUNERAL DIRECTOR <u>Ellsworth Arracost</u>		ADDRESS <u>4600 Liberty Hgts. Ave. 7</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



5324

## CERTIFICATE OF DEATH

Reg. Dist. No. 47

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>BALTIMORE</b>		MARYLAND		STATE <b>MARYLAND</b>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>BALTIMORE</b>			
X TOWN <b>FORT HOWARD</b>		23 DAYS		STREET ADDRESS (If rural give location) <b>6614 FAIT AVENUE</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>VETERANS ADMINISTRATION HOSPITAL</b>				50			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <b>JUNE 2 1955</b>			
<b>GUS J. FEDDER</b>							
5. SEX: <b>MALE</b>	6. COLOR OR RACE: <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>MARRIED</b>	8. DATE OF BIRTH: <b>2-14-92</b>	9. AGE last birthday: <b>63</b> yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>MECHANIC</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>DIESEL</b>		11. BIRTHPLACE (State or foreign country): <b>SWEDEN</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME: <b>JOHN FEDDER</b>				14. MOTHER'S MAIDEN NAME: <b>LENA CARLSON</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <b>YES</b> (If Yes, give war or dates of service): <b>WW I</b>		16. SOCIAL SECURITY NO.: <b>217-09-0539</b>		17. INFORMANT & ADDRESS: <b>CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MARYLAND</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>CARCINOMA OF LUNG</b>						UNKNOWN	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>PULMONARY EMPHYSEMA, CHRONIC, SEVERE ARTERIOSCLEROTIC HEART DISEASE</b>						UNKNOWN	
19A. DATE OF OPERATION: <b>7</b>		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from MAY 10, 1955, to JUNE 2, 1955, that I examined the deceased and that death occurred at 3:40AM, from the causes and on the date stated above.							
SIGNATURE <b>Francis G. Dickey</b>				ADDRESS		DATE SIGNED	
<b>FRANCIS G. DICKEY, M.D., Chief, Medical Service, V.A.H., FORT HOWARD, MARYLAND</b>				<b>6-2-55</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>5-6-55</b>		NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL CEMETERY BALTIMORE, MARYLAND</b>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <b>6-3-55</b>		REGISTRAR'S SIGNATURE <b>JST</b>		ADDRESS <b>Walter Brooks Bradley, 700 Willow Spring Baltimore (Dundalk) Md.</b>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND 5325

STATE DEPARTMENT OF HEALTH

05319

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>52</u> TOWN <u>CATONSVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTO.</u> <u>1314</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90</u> <u>HOUSE IN PINES HOME</u>		STREET ADDRESS (If rural, give location) <u>717 STAMFORD RD.</u> ✓	
3. NAME OF DECEASED (Type or Print) <u>ALIDA</u> (First) <u>GERRITS</u> (Middle) <u>FILLING</u> (Last)		4. DATE OF DEATH (Month) <u>6</u> (Day) <u>8</u> (Year) <u>1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Nov. 11, 1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	9. AGE last birthday <u>77</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>HOLLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN GERRITS</u>		14. MOTHER'S MAIDEN NAME <u>ALIDA DEURITER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Mr. Bonner 717 Stamford Rd.</u>			
15. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH.			
Immediate cause (a) <u>Cerebral Hemorrhage</u>			<u>3 da.</u>
Antecedent cause(s) (b) <u>Hypertensive Cardio-Vascular Renal Disease</u>			<u>10 yr (?)</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>N</u>		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6-5</u> , 19 <u>55</u> , to <u>6-8</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6-7</u> , 19 <u>55</u> , and that death occurred at <u>2</u> <u>P.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Thomas R. Gallagher M.D.</u>		ADDRESS <u>6209 Frederick Rd. Balto. 28 Md.</u>	
DATE SIGNED <u>6-9-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE <u>6-10-55</u>	NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>
LOCATION (City, town, or county) <u>Balto</u>		(State) <u>Md.</u>	
DATE REC'D BY LOCAL REG. <u>6-10-55</u>		REGISTRAR'S SIGNATURE <u>V.E. Harry</u>	
24. FUNERAL DIRECTOR <u>Truly Funeral Home - Catonsville, Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

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5326

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

05320

Reg. Dist. No. 37

1. PLACE OF DEATH- COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>SPARKS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>MARYLAND - Sparks</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>YORK ROAD</u>		STREET ADDRESS (If rural, give location) <u>YORK ROAD</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>CLARENCE</u>	(Middle)	(Last) <u>FOSTER</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>MAR. 31, 1878</u>
9. AGE last birthday <u>77</u> yrs.		10. DATE OF DEATH <u>JUNE 24</u> 19 <u>55</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE FOSTER</u>		14. MOTHER'S MAIDEN NAME <u>RACHEL SPARKS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>FAMILY RECORDS</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>420.1 Coronary occlusion</u>			
Antecedent cause(s) (b) <u>Disease or conditions, if any, giving rise to the above cause, stating the underlying cause last.</u>			
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE (Degree or title) <u>A. M. France M.D.</u>		DATE SIGNED <u>6/24/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>JUNE 22, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>JE-SOPS CEMETERY</u>	LOCATION (City, town, or county) (State) <u>COCKEYSVILLE, BALTO. CO., MD.</u>
DATE REC'D BY LOCAL REG. <u>29 June 1955</u>	REGISTRAR'S SIGNATURE <u>Wm. Ernest MacRae</u>	24. FUNERAL DIRECTOR ADDRESS <u>7-11 W. 11th St. Baltimore, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **05321**  
**5327** CERTIFICATE OF DEATH

Reg. Dist. No. **31**

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Balto.</b>	MARYLAND	STATE <b>Md.</b>	COUNTY <b>Balto.</b>
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <b>55 Towson</b>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Towson</b>	<b>55</b>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>1205 York Rd.</b>		STREET ADDRESS (If rural give location) <b>1205 York Rd.</b>	<b>1</b>
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<b>HELEN VIRGINIA FOSTER</b>		OF DEATH: <b>June 20, 1955</b>	
5. SEX: <b>female</b>	6. COLOR OR RACE: <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>married</b>	8. DATE OF BIRTH: <b>Oct. 10, 1894</b>
9. AGE last birthday: <b>60</b> yrs		10. IF UNDER 1 YEAR: Months Days	11. IF UNDER 24 HRS: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <b>Joseph Bainberger</b>		14. MOTHER'S MAIDEN NAME: <b>Virginia Poole</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <b>no</b> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <b>Mr. Edwin K. Foster - 1205 York Rd.</b>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <b>260X</b>		<b>6 weeks</b>	
ANTECEDENT CAUSE (S)		<b>+ 2 yrs.</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		<b>10 yrs.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Nov. 4, 1953</b> , to <b>6/20, 1955</b> , that I last saw the deceased alive on <b>6/18, 1955</b> , and that death occurred at <b>10:30 P. M.</b> from the causes and on the date stated above.			
SIGNATURE <b>Harry F. Humphreys</b>		M. D. <b>1101 N. Calvert St. Baltimore, Md. 6/21/55</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>6/23/55</b>	
NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		LOCATION (City, town, or county) <b>Baltimore, Md.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>6-23-55</b>		REGISTRAR'S SIGNATURE <b>Wm. J. Tidwell</b>	
24. FUNERAL DIED FOR		ADDRESS <b>26 W. J. Tidwell &amp; Son, Baltimore, Md.</b>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



5328

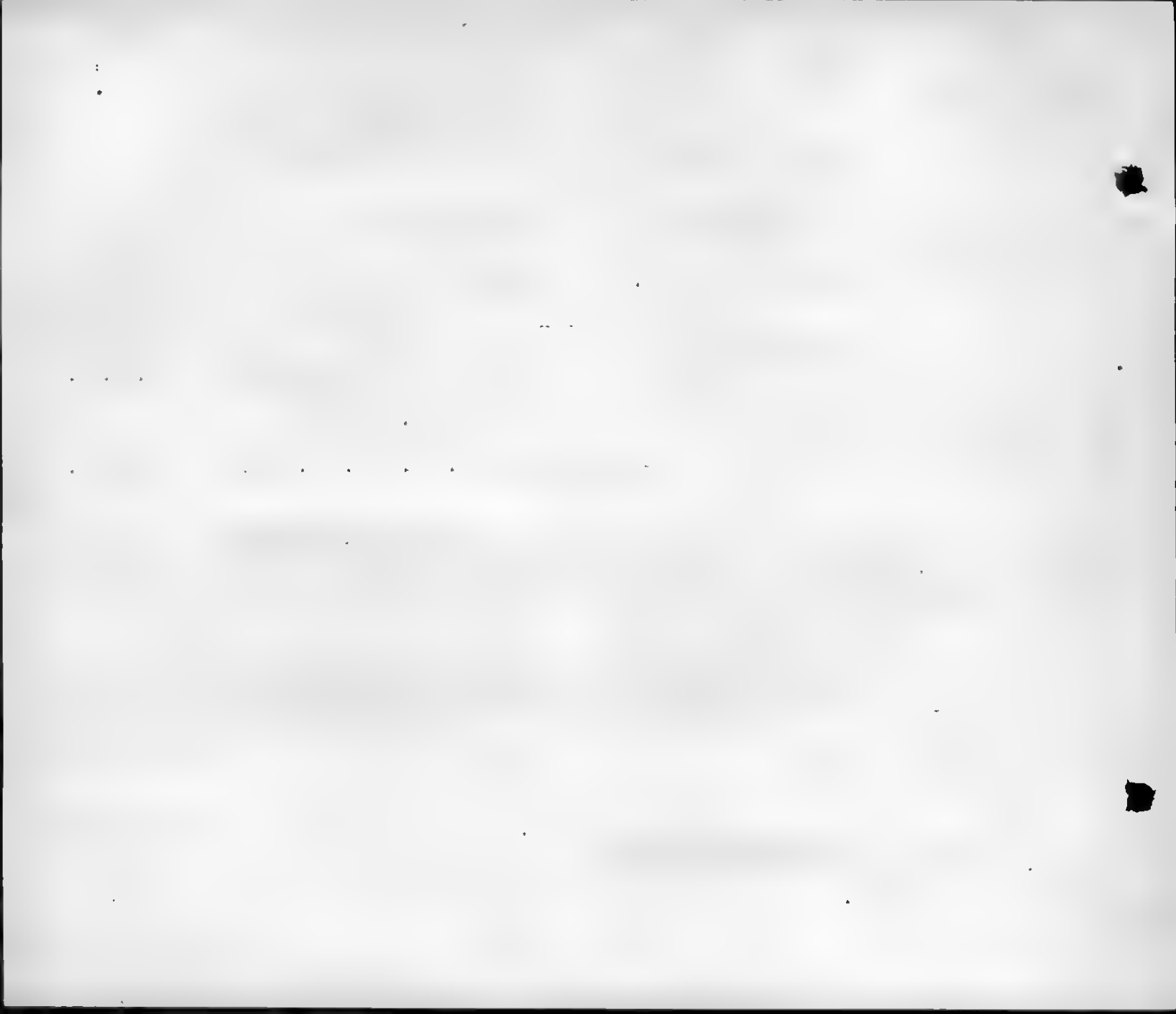
CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>BALTIMORE</b> CITY (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b> HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>VETERANS ADMINISTRATION HOSPITAL</b>	MARYLAND LENGTH OF STAY (in this place) <b>64 DAYS</b>	STATE <b>MARYLAND</b> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>BALTIMORE</b> STREET ADDRESS (If rural give location) <b>1846 WILKENS AVENUE</b>	COUNTY <b>2801 4</b>
3. NAME OF DECEASED: (Type or Print) <b>WILLIAM J. FOSTER</b>		4. DATE (Month) (Day) (Year) OF DEATH: <b>JUNE 22 19 55</b>	
5. SEX: <b>MALE</b>	6. COLOR OR RACE: <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>MARRIED</b>	8. DATE OF BIRTH: <b>5-9-75</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>ELECTRICIAN</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>STEEL PLANT</b>	
11. BIRTHPLACE (State or foreign country): <b>NORTH POINT, PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME: <b>EPHRIAM FOSTER</b>		14. MOTHER'S MAIDEN NAME: <b>MAGGIE L. MCCLELLAN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>YES</b> (If Yes, give war or dates of service) <b>SAV</b>		16. SOCIAL SECURITY NO. <b>213-07-1313</b>	
17. INFORMANT & ADDRESS: <b>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.</b>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>420.1</b> IMMEDIATE CAUSE ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (A) <b>MYOCARDIAL INFARCT; ARTERIOSCLEROTIC</b> <b>22000 OCCLUSION OF LEFT CORONARY ARTERY</b> (B) <b>INFARCT, LEFT CEREBRUM</b> DUE TO (C)		<b>4 WEEKS</b> <b>UNKNOWN</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <b>4-29-55</b>		19B. MAJOR FINDINGS OF OPERATION: <b>TRANSURETHRAL RESECTION</b>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Findings: <b>Nodular hyperplasia of prostate</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <b>VA</b>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>APR. 19, 1955</b> , to <b>JUNE 22, 1955</b> , and that death occurred at <b>12:05 PM</b> , from the causes and on the date stated above. SIGNATURE <b>William B. Vandegrift</b> ADDRESS <b>M. D. VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>6-23-55</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>June 24, 1955</b>	
NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
DATE REC'D BY LOCAL REGISTRAR <b>6-24-55</b>		REGISTRAR'S SIGNATURE <b>A. W. Hedrick</b>	
24. FUNERAL DIRECTOR <b>WM. COOK-BLIGHT INC.</b>		ADDRESS <b>6009 HARFORD RD BALTO. MD.</b>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, #5323

5329

CERTIFICATE OF DEATH

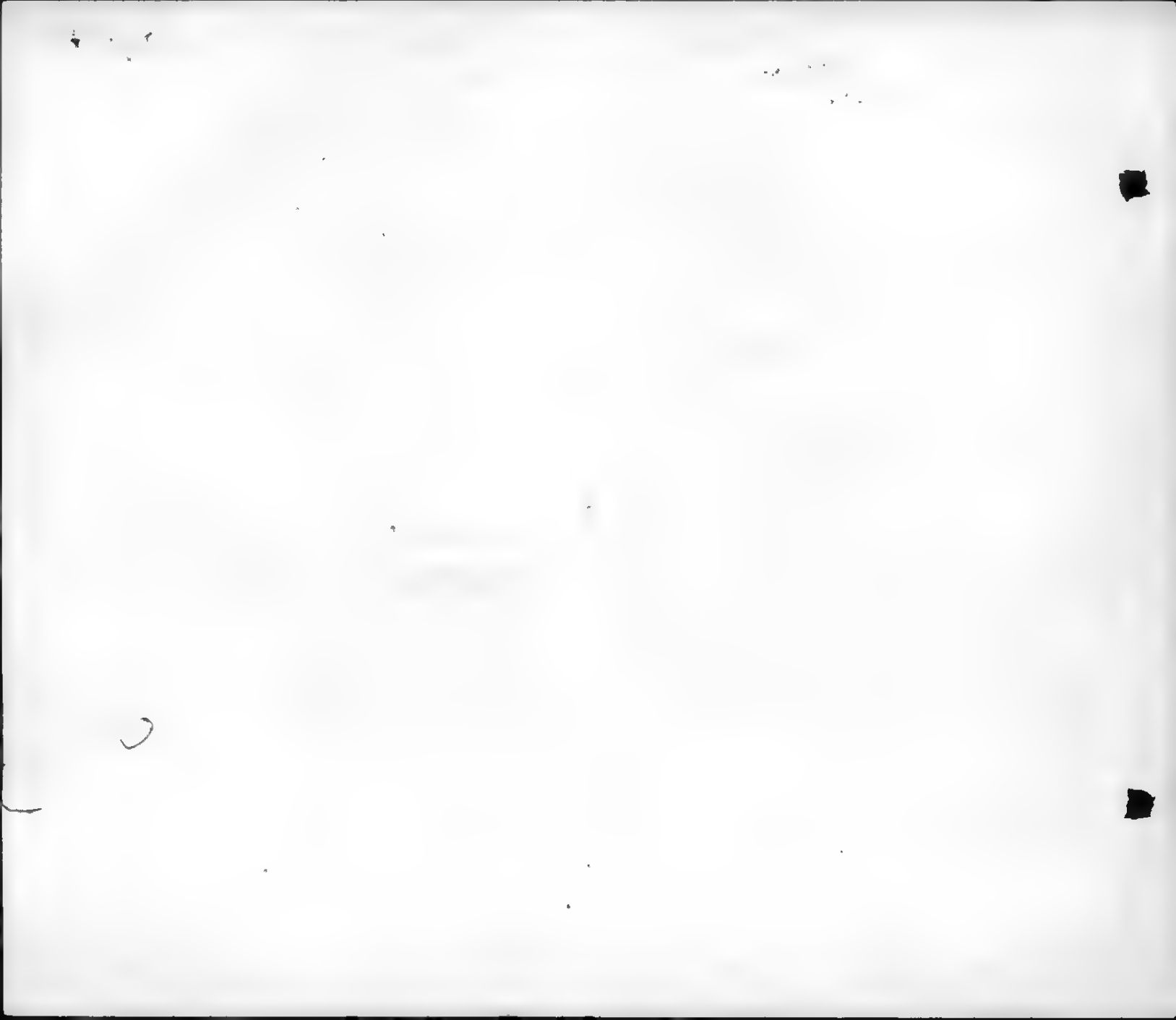
Reg. Dist. No. 42

1 PLACE OF DEATH:		2 USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Halethorne, Balto.</u> MARYLAND		STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> <u>3Y01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Craddock's Nursing Home</u> <u>1900 Northeast Ave.</u>		STREET ADDRESS (If rural give location) <u>1918 Riggs Ave.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Matthews B. Fraling</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>6-8-</u> <u>19 55</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE MARRIED. WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH: <u>Oct. 6, 1904</u>
9. AGE last birthday: <u>50</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Box Cutter</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Gordon Paper Box</u>	
11. BIRTHPLACE (State or foreign country): <u>Taneytown, Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Simon Fraling</u>		14. MOTHER'S MAIDEN NAME: <u>Josephine Cook</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>WWII</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Simon Fraling 1603 McKean Ave.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Carcinoma of right lung</u>			
ANTECEDENT CAUSE (S) <u>Hemiplegia of left side</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 5, 1955</u> to <u>June 8, 1955</u> , that I last saw the deceased alive on <u>June 7, 1955</u> and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Sted Bradley</u>		DATE SIGNED <u>June 27, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6-13-1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6-13-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>	
24. FUNERAL DIRECTOR <u>Arington S. Phillips</u>		ADDRESS <u>1808 N. Monroe Street</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



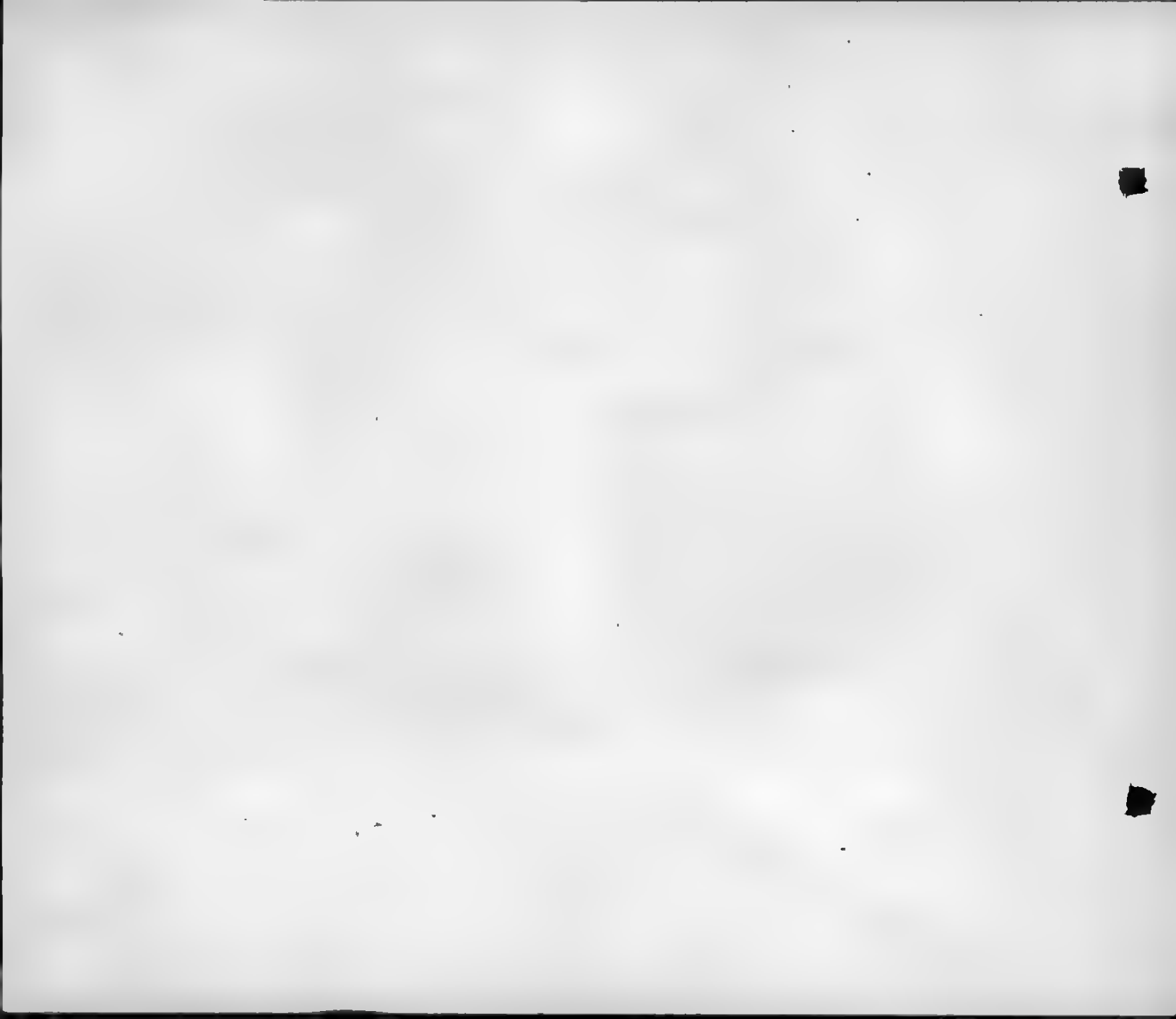
5330

## CERTIFICATE OF DEATH

Reg. Dist. No. 50

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>MD</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR TOWN) <u>Catonsville</u>	LENGTH OF STAY (in this place) <u>since 5/18/50</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore, 18 3rd-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		STREET ADDRESS (If rural give location) <u>3047 Abell Ave.</u>	
3. NAME OF DECEASED: (First) <u>Katherine</u> (Middle) <u>Frederick</u> (Last)		4. DATE (Month) (Day) (Year) OF DEATH: <u>6/25/1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED: <u>Divorced</u>	8. DATE OF BIRTH: <u>3/21/91</u>
9. AGE last birthday <u>64</u> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Baltimore</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>Charles H. Kaufman</u>	
14. MOTHER'S MAIDEN NAME: <u>Emma Louise Nicholson</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>unk.</u>	
16. SOCIAL SECURITY NO. <u>unk.</u>		17. INFORMANT & ADDRESS: <u>This Hospital's Records</u>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
153X IMMEDIATE CAUSE		(A) <u>Cardiopulmonary thrombosis</u> hours	
ANTECEDENT CAUSE (S):		(B) <u>Cachexia and inanition</u> months	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C) <u>Multiple intrabdominal metastases</u> ??	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		<u>Infarctive cardiac fibrosis</u> years	
19A. DATE OF OPERATION: <u>?/?/50</u>	19B. MAJOR FINDINGS OF OPERATION: <u>Annular carcinoma ascending colon</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>5/18/50</u> , 19 <u>50</u> , to <u>6/25</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6/25</u> , 19 <u>55</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Bruno Radauskis</u>		ADDRESS <u>M.D. Spring Grove St. Hosp.</u> DATE SIGNED <u>6/25/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF <u>June 28 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Green Ridge</u>	LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
DATE REC'D BY LOCAL REGISTRAR <u>6/25/55</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>Wm. Cook Inc.</u>	ADDRESS <u>1217 St Paul St</u>

MARGIN RESERVED FOR BINDING



5331

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL, and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN <u>Uppersco Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>RAYMOND - W - GANSKE Jr</u>				OF DEATH: <u>June 28</u> 19 <u>55</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>Oct 31 - 1949</u>	
9. AGE last birthday: <u>5</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>NO</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>✓</u>		11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME: <u>Raymond W Gauske, Sr.</u>				14. MOTHER'S MAIDEN NAME: <u>Hedra Bittle</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>NO</u>				16. SOCIAL SECURITY NO.: <u>NO</u>			
17. INFORMANT & ADDRESS: <u>RW Gauske Sr, Uppersco Md</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
193X IMMEDIATE CAUSE (A) <u>Brain tumor</u>							
ANTECEDENT CAUSE (S) DUE TO <u>(Pontine glioma)</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/29</u> ..., 1952, to <u>6/28</u> ..., 1955, that I last saw the deceased alive on <u>6/27</u> ..., 1955, and that death occurred at <u>10AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>W H. Howard</u>				DATE SIGNED <u>6/28/55</u>			
M. D. <u>Manchester Md</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>June 30/55</u>		<u>Grace</u>		<u>Balto Co Md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>6-30-55</u>		<u>Harry D. Elme</u>		<u>Edw &amp; Tipton, Hampstead Md</u>			

MARGIN RESERVED FOR BINDING

IS 'A' OVER

536. 9

1931

5332

05326

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. ....

## I. PLACE OF DEATH:

COUNTY

Balt.

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

TOWN

Pikesville 8

LENGTH OF STAY (in this place)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

COUNTY

Md. Balt. City

CITY (If outside corporate limits write RURAL and give nearest town)

OR TOWN

Balt 15

34.3.4

STREET ADDRESS

(If rural, give location)

3315 Charles Lane.

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

JOSEPH

GEARTNER

4. DATE OF DEATH

(Month)

(Day)

(Year)

June 12 1955

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Male

White

Married Jan 20, 1914.

45 yrs.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

Salesman Real Estate

Balt. Md.

U.S.A.

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

Benj. Gartner

Hilda. Steiner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT &amp; ADDRESS:

No.

212-10-9989

Luc Rosenbaum (sister)

## 13. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

422.1

Immediate cause

(a)

DUE TO

Coronary Occlusion

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

DUE TO

None

(c)

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

None

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

None

None

INTERVAL BETWEEN ONSET AND DEATH

1 hr

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING CAUSE OF DEATH ☐

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

CHIEF MEDICAL EXAMINER

DATE SIGNED

D.D. Caples

M.D. DEPUTY MEDICAL EXAMINER

6-12-55

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

6-12-55

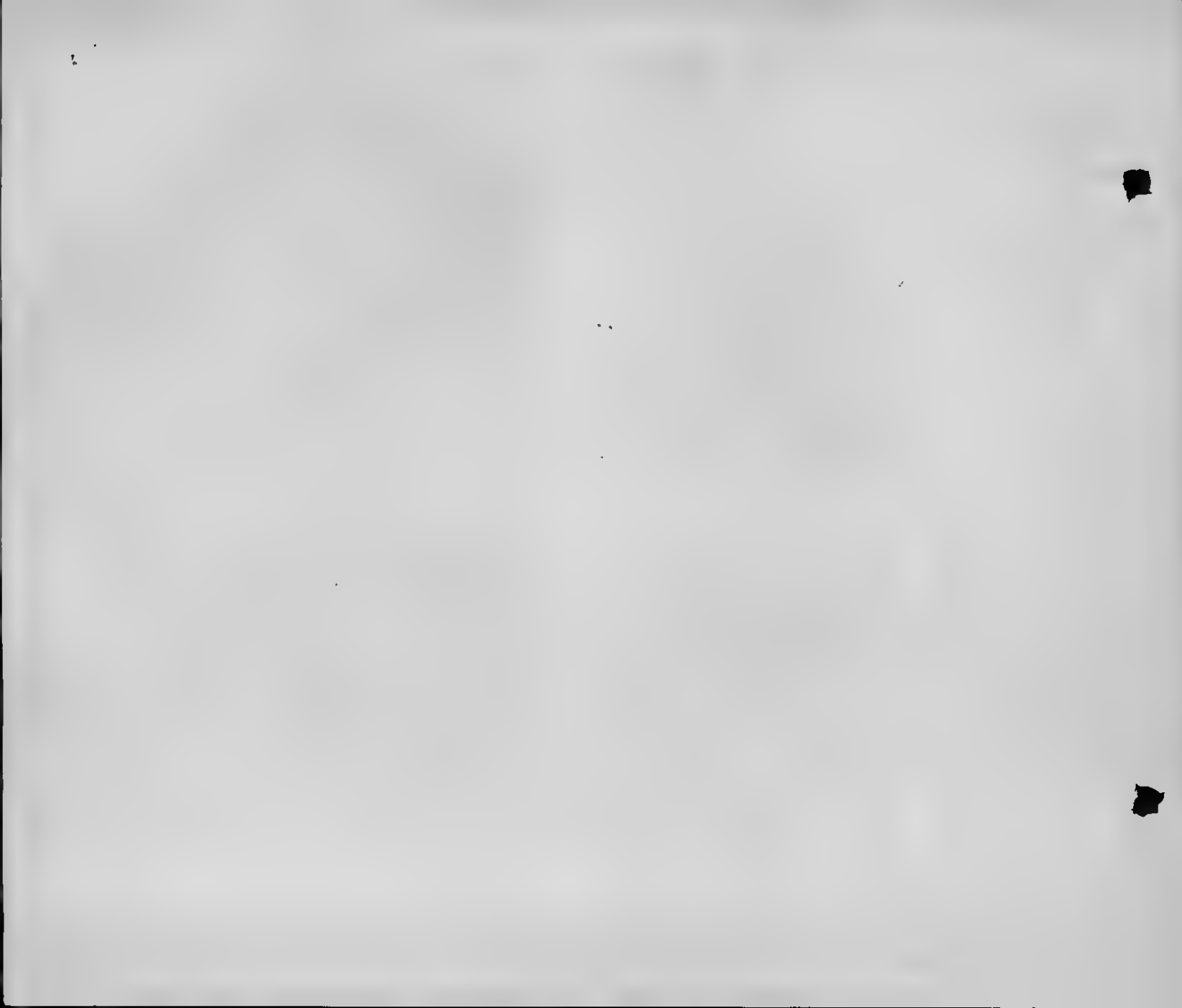
H. H. Hedrick

2100 Eutaw Pl

Balt. Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

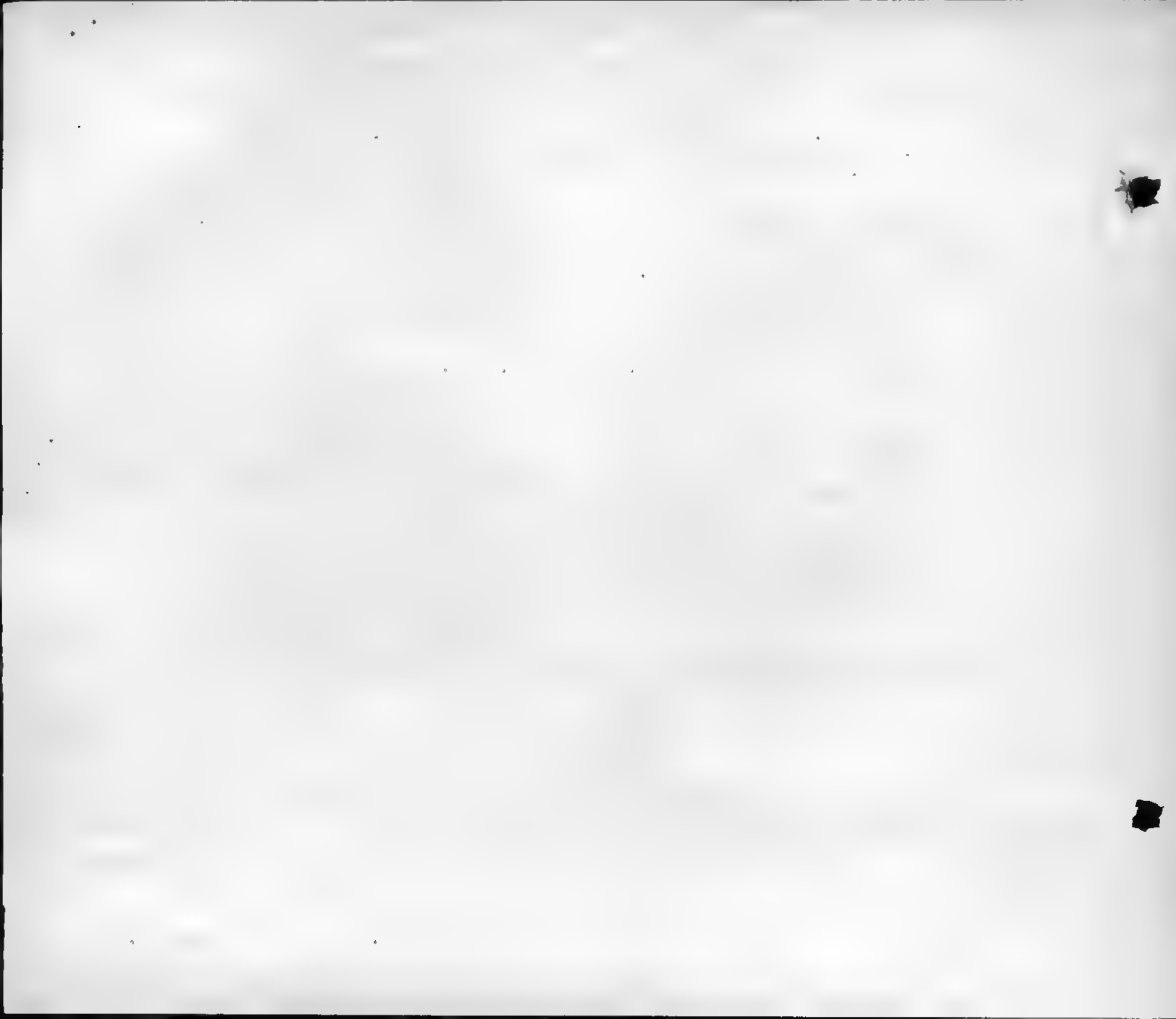
5333

## CERTIFICATE OF DEATH

Reg. Dist. No.

05327

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
TOWN <u>Catonsville</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>329 Harlem Lane</u>		<u>formerly of 820 N. Hollins St.</u>	
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH:	
(First) <u>ROBERT</u>	(Middle) <u>G.</u>	(Last) <u>GENS</u>	(Month) <u>June</u> (Day) <u>25</u> , (Year) <u>1955</u>
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>May 25, 1862</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Clerk (rtd)</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>J. P. Gilpin Co.</u>	11. BIRTHPLACE (State or foreign country): <u>Md.</u>
13. FATHER'S NAME: <u>Carl Gens</u>		14. MOTHER'S MAIDEN NAME: <u>Amelia --</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u>		17. INFORMANT & ADDRESS: <u>Glen Burnie, Md. Mr. Charles V. Cearfoss-306 Shipley Ave.</u>	
16. SOCIAL SECURITY NO. <u>no</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
450.0 IMMEDIATE CAUSE			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <u>Pulmonary edema</u>			
DUE TO			
(B) <u>chronic heart failure</u>			
DUE TO			
(C) <u>Arteriosclerosis &amp; senile</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1954</u> , to <u>6.25, 1955</u> , that I last saw the deceased alive on <u>6.25, 1955</u> , and that death occurred at <u>9:45 p. M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Stanley Anker</u>		DATE SIGNED <u>6.27.55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/29/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Broadfording Cem.</u>		LOCATION (City, town, or county) (State) <u>Broadfording, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6-27-55</u>		REGISTRAR'S SIGNATURE <u>Wm. J. Tichenor</u>	
FUNERAL DIRECTOR <u>Wm. J. Tichenor</u>		ADDRESS <u>Sous-Bault</u>	



5374  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05328  
Reg. Dist.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Baltimore</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY <b>Baltimore</b>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <b>Dundalk</b>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <b>Dundalk</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>428 Trappe Road</b>		STREET ADDRESS (If rural, give location) <b>428 Trappe Road</b>	
3. NAME OF DECEASED: (First) <b>EDWARD</b> (Middle) <b>A.</b> (Last) <b>GINSKI</b>		4. DATE OF DEATH <b>June 9, 1955</b>	
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Married</b>	8. DATE OF BIRTH: <b>Nov. 9, 1919</b>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <b>Maintaince Man</b>		10b. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday: <b>35</b> yrs.
11. BIRTHPLACE (State or foreign country): <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <b>Rudolph Ginski</b>		14. MOTHER'S MAIDEN NAME: <b>Mary Drozd</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
17. INFORMANT & ADDRESS: <b>Mrs Mary Ginski 2106 Eastern Avenue</b>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
<p><b>976X</b></p> <p>Immediate cause (a) <b>Gunshot wound of head.</b></p> <p>DUE TO</p> <p>Antecedent cause(s) (b)</p> <p>Diseases or conditions, if any, giving rise to the above cause DUE TO</p> <p>stating underlying cause last (c)</p>		

11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <b>Home</b>
21c. (City or town) <b>428 Trappe Road, Dundalk, Balto. Co., Md.</b> (County) (State)	
21d. TIME (Month) <b>June</b> (Day) <b>9</b> (Year) <b>1955</b> (Hour) <b>6 p.</b> (Minute) <b>M.</b>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>
21f. HOW DID INJURY OCCUR? <b>Shot self in head.</b>	

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

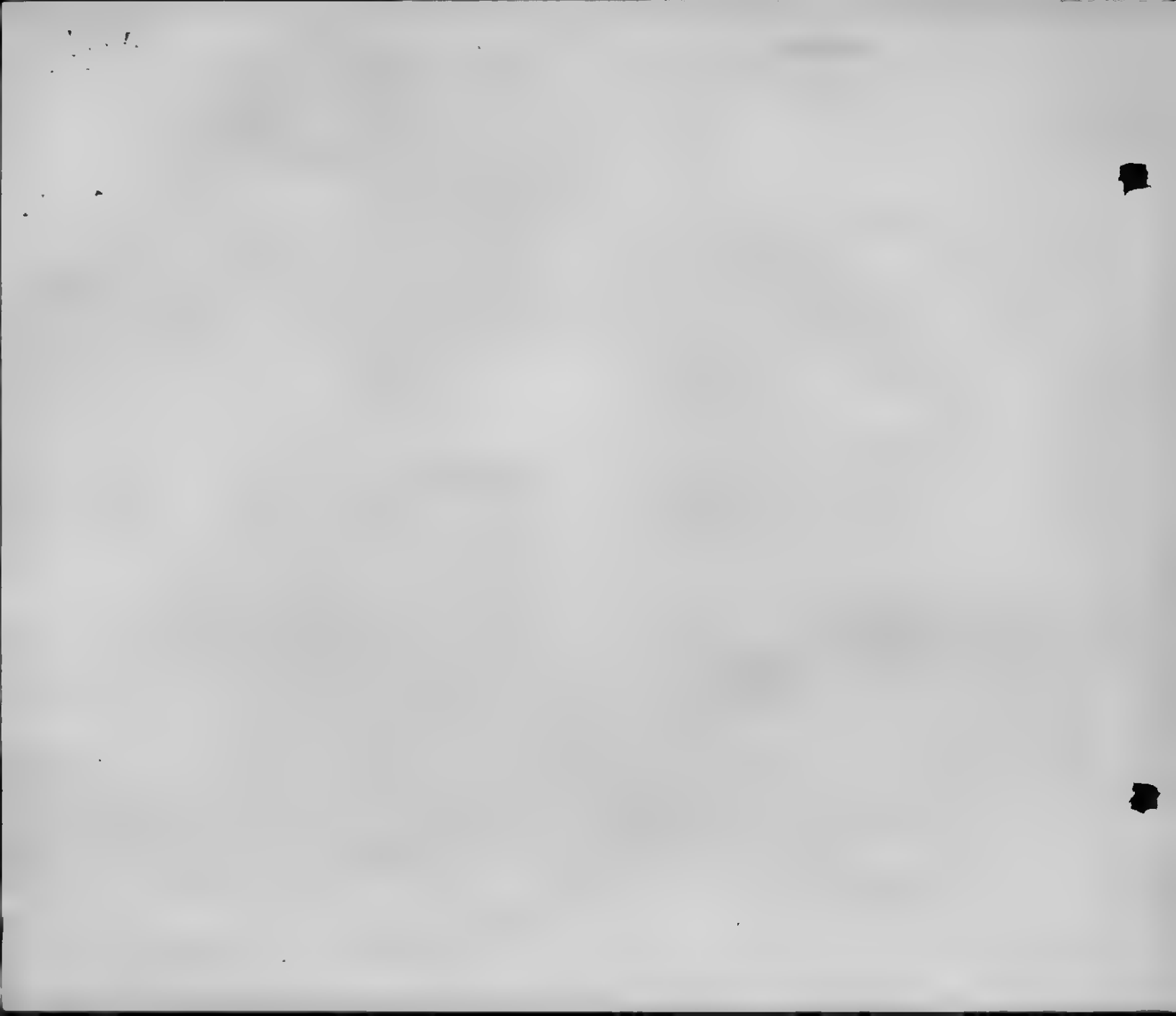
SIGNATURE *Karl F. Ginski* CHIEF MEDICAL EXAMINER ☐ DATE SIGNED **June 10, 1955**  
M. D. DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☐

23. BURIAL, CREMATION, REMOVAL (Specify): <b>Burial</b>	DATE THEREOF <b>June 11, 1955</b>	NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus</b>	LOCATION (City, town, or county) <b>Baltimore</b> (State)
DATE REC'D BY LOCAL REG. <b>10-58</b>	REGISTRAR'S SIGNATURE <i>[Signature]</i>	24. FUNERAL DIRECTOR <b>Lilly &amp; Zeiler Inc., 403 S. Wolfe St.</b>	ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

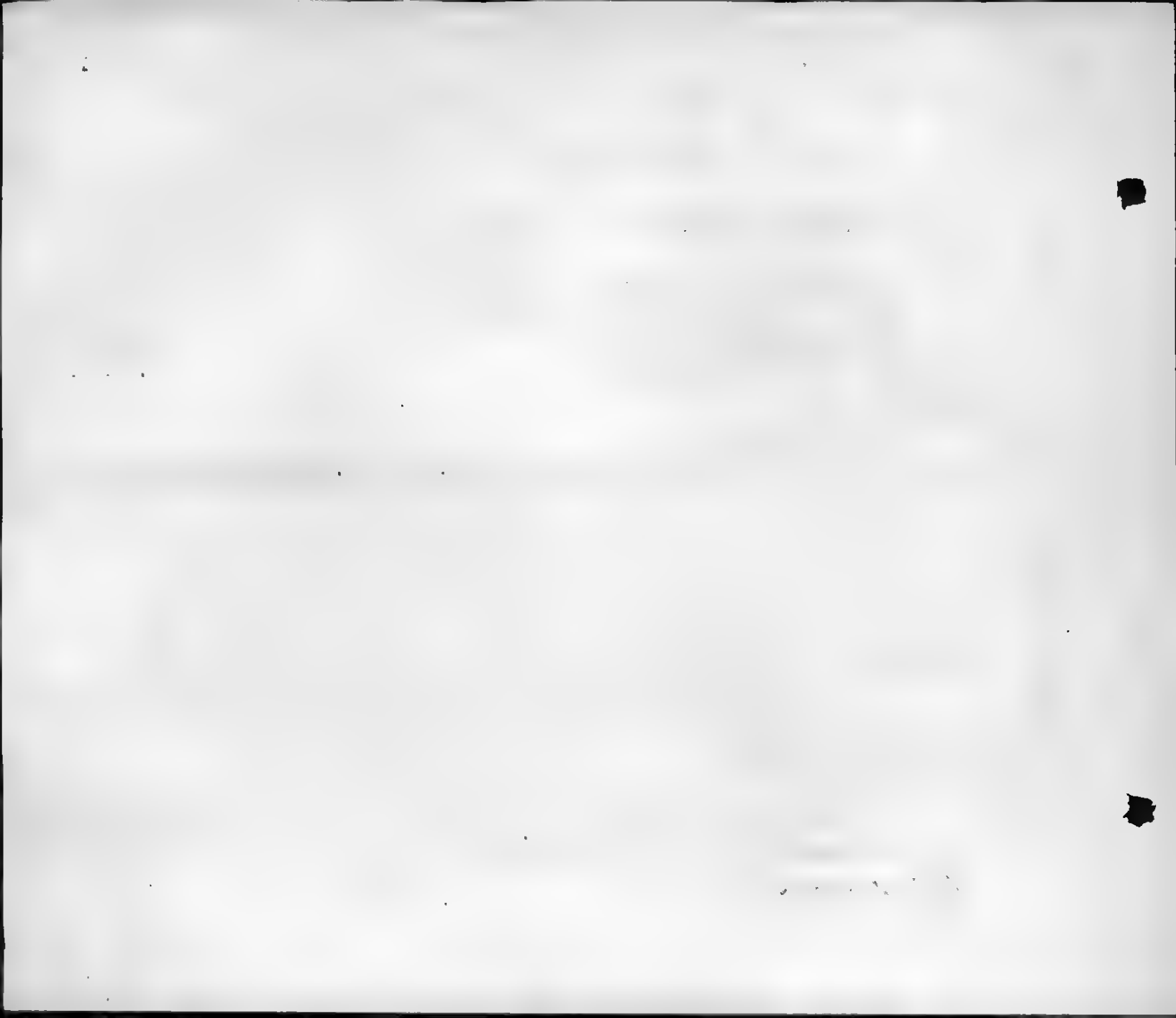
05329

5334

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>BALTIMORE</b>		MARYLAND		STATE <b>MARYLAND</b>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>FORT HOWARD</b>		<b>211 DAYS</b>		TOWN <b>BALTIMORE</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>VETERANS ADMINISTRATION HOSPITAL</b>				<b>2420 EAST FAYETTE STREET</b>			
3. NAME OF DECEASED (Type or Print)		(First) <b>WILLIAM</b>		(Middle) <b>E.</b>		(Last) <b>GOETZ</b>	
4. DATE OF DEATH		5. SEX: <b>MALE</b>		6. COLOR OR RACE: <b>WHITE</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>SINGLE</b>	
<b>JUNE 22 19 55</b>				8. DATE OF BIRTH: <b>7-15-99</b>		9. AGE last birthday: <b>55</b> yrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>PAINTER</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>SELF EMPLOYED</b>		11. BIRTHPLACE (State or foreign country): <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME: <b>DANIEL GOETZ</b>				14. MOTHER'S MAIDEN NAME: <b>ELIZABETH CLINTON</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>YES WW II</b>				16. SOCIAL SECURITY NO. <b>220-07-4198</b>			
17. INFORMANT & ADDRESS: <b>CLIN.REC., VET.ADM.HOSP., FT.HOWARD, MD.</b>				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>CARCINOMA OF RIGHT PALATE</b>				UNKNOWN			
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH: (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>NOV. 23, 1954</b> , to <b>JUNE 22, 1955</b> , and that death occurred at <b>12:45 PM</b> , from the causes and on the date stated above.							
SIGNATURE <b>WILLIAM B. VANDEGRIET</b>				ADDRESS <b>M. D. VAH, FORT HOWARD, MARYLAND</b>			
DATE THEREOF <b>June 27, 1955</b>				DATE SIGNED <b>6/23/55</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		LOCATION (City, town, or county) <b>BALTIMORE, MARYLAND</b>			
DATE REC'D BY LOCAL REGISTRAR <b>6-24-55</b>		REGISTRAR'S SIGNATURE <b>R. W. Hedrick</b>		24. FUNERAL DIRECTOR ADDRESS <b>JOHN A. MORAN FUNERAL HOME 3000 E. BALTO. BALTO. MD. ST.</b>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5335

## CERTIFICATE OF DEATH

Reg. Dist. No. 053307

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Baltimore</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>Baltimore</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <i>Stencoe</i>	<i>Life</i>	TOWN <i>Stencoe</i> X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
<i>00</i>		<i>Upper Stencoe Rd</i>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<i>Augustus Price Gorsuch</i>		DATE OF DEATH: <i>6-23 1955</i>	
5. SEX: <i>male</i>	6. COLOR OR RACE: <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>single</i>	8. DATE OF BIRTH: <i>Nov 17, 1870</i>
9. AGE last birthday		IF UNDER 1 YEAR IF UNDER 24 HRS.	
<i>84</i> yrs.		Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>farm owner farm</i>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <i>Balto Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY: <i>U.S.A.</i>	
13. FATHER'S NAME: <i>Thomas T. Gorsuch</i>		14. MOTHER'S MAIDEN NAME: <i>Sarah T. Mays</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT'S ADDRESS: <i>Miss Edith Gorsuch, Stencoe Md.</i>			
15. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
450.0			
IMMEDIATE CAUSE (A)		<i>generalized arteriosclerosis</i>	
DUE TO		<i>years</i>	
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.		DUE TO	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Permissive anemia</i>		<i>years</i>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Feb</i> , 1951, to <i>June</i> , 1955, that I last saw the deceased alive on <i>June 27</i> , 1955, and that death occurred at <i>8 A</i> M, from the causes and on the date stated above.			
SIGNATURE <i>Elizabeth B. Sherrill M.D.</i>		ADDRESS <i>Codorusville Md.</i> DATE SIGNED <i>6/23/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>6-25-55</i>	
NAME OF CEMETERY OR CREMATORY <i>Family Burial Plot</i>		LOCATION (City, town, or county) (State) <i>Stencoe, Balto. Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>24 June 1955</i>		REGISTRAR'S SIGNATURE <i>Anna Pernis MacRae</i>	
24. FUNERAL DIRECTOR <i>Brooks Funeral Service, Sparks, Md.</i>		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1955  
83  
1890

1955

5336

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Baltimore</i>	MARYLAND	STATE <i>Md</i>	COUNTY <i>Baltimore</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Owings Mills</i>	LENGTH OF STAY (in this place) <i>18 years</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Owings Mills</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Timbergrove Road</i>	STREET ADDRESS (If rural give location) <i>Timbergrove Road</i>		
3. NAME OF DECEASED: (First) (Middle) (Last) <i>Charles Edgar Grove</i>		4. DATE (Month) (Day) (Year) OF DEATH: <i>June 13 1955</i>	
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Y</i>	8. DATE OF BIRTH: <i>April 10, 1874</i>
9. AGE last birthday <i>81</i> yrs.		IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Book Keeper</i>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <i>Waynesboro, Penn.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>William F. Grove</i>		14. MOTHER'S MAIDEN NAME: <i>Barbara Garver</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>215030886</i>	
17. INFORMANT & ADDRESS: <i>Mrs. Carrick - same (Mrs. Edw. H.)</i>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
422.1 IMMEDIATE CAUSE			
(A) <i>Pulmonary edema</i>			
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(B) <i>Arteriosclerotic C.V.D.</i>			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <i>U</i>	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>June, 1948</i> , to <i>June, 1955</i> , that I last saw the deceased alive on <i>12 June, 1955</i> , and that death occurred at <i>6:30 AM</i> , from the causes and on the date stated above.			
SIGNATURE <i>Charles H. Williams</i>		ADDRESS <i>M.D. Pineville, Md</i> DATE SIGNED <i>13 June 55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>	DATE THEREOF <i>6/14/55</i>	NAME OF CEMETERY OR CREMATORY <i>Linden Park</i>	LOCATION (City, town, or county) (State) <i>Fedders Rd Baltimore Md</i>
DATE REC'D BY LOCAL REGISTRAR <i>6-14-55</i>	REGISTRAR'S SIGNATURE <i>Mary B. Eline</i>	4. FUNERAL DIRECTOR ADDRESS <i>Walter Z. Gae Waynesboro, Pa</i>	

MARGIN RESERVED FOR BINDING

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JUN 17 1966

14706

5337

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Owings Mills</u>		8 mo.		TOWN <u>Silver Spring</u>		15562	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rosewood State Training School</u>				STREET ADDRESS (If rural, give location) <u>811 Burlington Avenue</u>			
3. NAME OF DECEASED: (First) <u>Lucy</u>		(Middle) <u>Marie</u>		(Last) <u>Hall</u>		4. DATE OF DEATH: (Month) <u>6</u> (Day) <u>9</u> (Year) <u>19 55</u>	
(Type or Print)							
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>	8. DATE OF BIRTH: <u>1/23/54</u>	9. AGE last birthday: <u>1</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>---</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>---</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>Albert Wilford Hall</u>				14. MOTHER'S MAIDEN NAME: <u>Marian Ann Gardiner</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>---</u> (If Yes, give war or dates of service) <u>---</u>				16. SOCIAL SECURITY No.: <u>---</u>		17. INFORMANT & ADDRESS: <u>Rosewood Records</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
752X Immediate cause (a) <u>Broncho-pneumonia</u>						<u>1 week</u>	
DUE TO							
Antecedent cause(s) (b) <u>Acute Bronchitis</u>						<u>1 day</u>	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last DUE TO							
(c) <u>Congenital internal hydrocephalus</u>						<u>Birth</u>	
11. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE		INJURY					
HOMICIDE							
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED		HOW DID INJURY OCCUR?			
OF		While at					
INJURY		M. work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>9/27</u> , 19 <u>54</u> , to <u>6/9</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6/9</u> , 19 <u>55</u> , and that death occurred at <u>5:40 a.m.</u> , from the causes and on the date stated above.							
SIGNATURE <u>J. B. Butler M.D.</u>				(DEGREE OR TITLE) ADDRESS <u>Owings Mills, Maryland</u>		DATE SIGNED <u>6/9/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>6/9/55</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
DATE REC'D BY LOCAL REG. <u>6-9-55</u>		REGISTRAR'S SIGNATURE <u>Mary B. Eline</u>		24. FUNERAL DIRECTOR <u>Frank Green, Sons Co</u>		ADDRESS <u>3605-14 St NW Wash. D.C.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUFFALO N. Y.

JUN 17 19

RECEIVED

5338

## CERTIFICATE OF DEATH

Reg. Dist. No. 34

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>BALTO.</b>	MARYLAND	STATE <b>MD</b>	COUNTY <b>BALTO.</b>
CITY (If outside corporate limits, write RURAL and give nearest town) <b>WILTONDALE</b>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <b>WILTONDALE</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>29 CEDAR AVE.</b>		STREET ADDRESS (If rural give location) <b>29 CEDAR AVE</b>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <b>GRACE</b>	(Middle) <b>JEAN</b>	(Last) <b>HAND</b>	(Month) <b>JUNE</b> (Day) <b>9</b> (Year) <b>1955</b>
5. SEX: <b>F</b>	6. COLOR OR RACE: <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>SINGLE</b>	8. DATE OF BIRTH: <b>JUNE 7, 1900</b>
9. AGE last birthday: <b>55</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): <b>NURSE</b>		10b. KIND OF BUSINESS OR INDUSTRY: <b>R.N.</b>	11. BIRTHPLACE (State or foreign country): <b>N.J.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME: <b>GEORGE C. HAND</b>	
14. MOTHER'S MAIDEN NAME: <b>KATHERINE TROTTER</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>	
16. SOCIAL SECURITY No.: <b>220-30-7380</b>		17. INFORMANT & ADDRESS: <b>MISS ELIZABETH HAND</b>	
18. MEDICAL CERTIFICATION		19. INTERVAL BETWEEN ONSET AND DEATH: <b>17-May-55</b>	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		20. AUTOPSY? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
(a) Immediate cause <b>442X</b>			
(b) Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. <b>Hypertensive Cardio Vascular Disease</b>			
(c) <b>Chronic Nephritis</b>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION: <b>1955</b>		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		22. PLACE (Home, farm, factory, street, office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
23. I hereby certify that I attended the deceased from <b>2 June, 1955</b> , to <b>9 June, 1955</b> , that I last saw the deceased alive on <b>9 June, 1955</b> , and that death occurred at <b>4:40 P.M.</b> from the causes and on the date stated above.			
SIGNATURE <b>Charles W. Edwards MD</b>		DATE SIGNED <b>10 June 1955</b>	
23. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		DATE THEREOF <b>6-12-1955</b>	
NAME OF CEMETERY OR CREMATORY <b>METH. EPISCOPAL CHURCH</b>		LOCATION City, town, or County (State) <b>NEW PROVIDENCE N.J.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>June 10 1955</b>		REGISTRAR'S SIGNATURE <b>RW</b>	
FUNERAL DIRECTOR <b>H.W. JENKINS &amp; SONS Co.</b>		ADDRESS <b>4905 YORK RD.</b>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



5339

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

## 1. PLACE OF DEATH:

COUNTY Balto MARYLAND  
 CITY (If outside corporate limits, write RURAL LENGTH OF STAY  
 OR and give nearest town) 10 yrs  
 TOWN Howblesburg  
 HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS 00

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE md COUNTY Balto  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR  
 TOWN Howblesburg X  
 STREET ADDRESS (If rural give location) 1

## 3. NAME OF DECEASED:

(First) (Middle) (Last)  
CHARLES-B-HARVEY

4. DATE (Month) (Day) (Year)  
 OF DEATH: June 18 19 55

## 5. SEX:

M

## 6. COLOR OR RACE:

W

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

M.

## 8. DATE OF BIRTH:

Oct 13-1885

## 9. AGE last birthday

69 yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

## 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

## 10B. KIND OF BUSINESS OR INDUSTRY:

Farm.

## 11. BIRTHPLACE (State or foreign country):

Manassas

## 12. CITIZEN OF WHAT COUNTRY:

U.S.A.

## 13. FATHER'S NAME:

Thomas Harvey

## 14. MOTHER'S MAIDEN NAME:

Sarah Brown

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service)

5No

## 16. SOCIAL SECURITY NO.

218-14-1545

## 17. INFORMANT &amp; ADDRESS:

Mrs Shas B Harvey, Howblesburg Md

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

163X

## IMMEDIATE CAUSE

(A)

DUE TO

Carcinoma, lung, bilateral

## ANTECEDENT CAUSE (B)

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(C)

## II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

## INTERVAL BETWEEN ONSET AND DEATH

8 months

## 19A. DATE OF OPERATION:

## 19B. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

## 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

## 21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

## 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

## 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1955, to June 18, 1955, that I last saw the deceased alive on June 18, 1955, and that death occurred at 6:00 P.M. from the causes and on the date stated above.

## SIGNATURE

George E McWilliams

## ADDRESS

M.D. Leintratown Maryland June 18/1955

## DATE SIGNED

## 23. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

## DATE THEREOF

June 21/55

## NAME OF CEMETERY OR CREMATORY

Pleasant Grove

## LOCATION (City, town, or county)

Balto Md

## (State)

## DATE REC'D BY LOCAL REGISTRAR

6-21-55

## REGISTRAR'S SIGNATURE

George B. Elmer

## 24. FUNERAL DIRECTOR

Edw E Tipton, Huntstead Md

## ADDRESS

MARGIN RESERVED FOR BINDING

THOMAS A. S.

NOT

11

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

The  
PLEASE WRITE PLAINLY IN UNFADING INK. Every item of information should be carefully supplied. 7  
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5340

Items 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

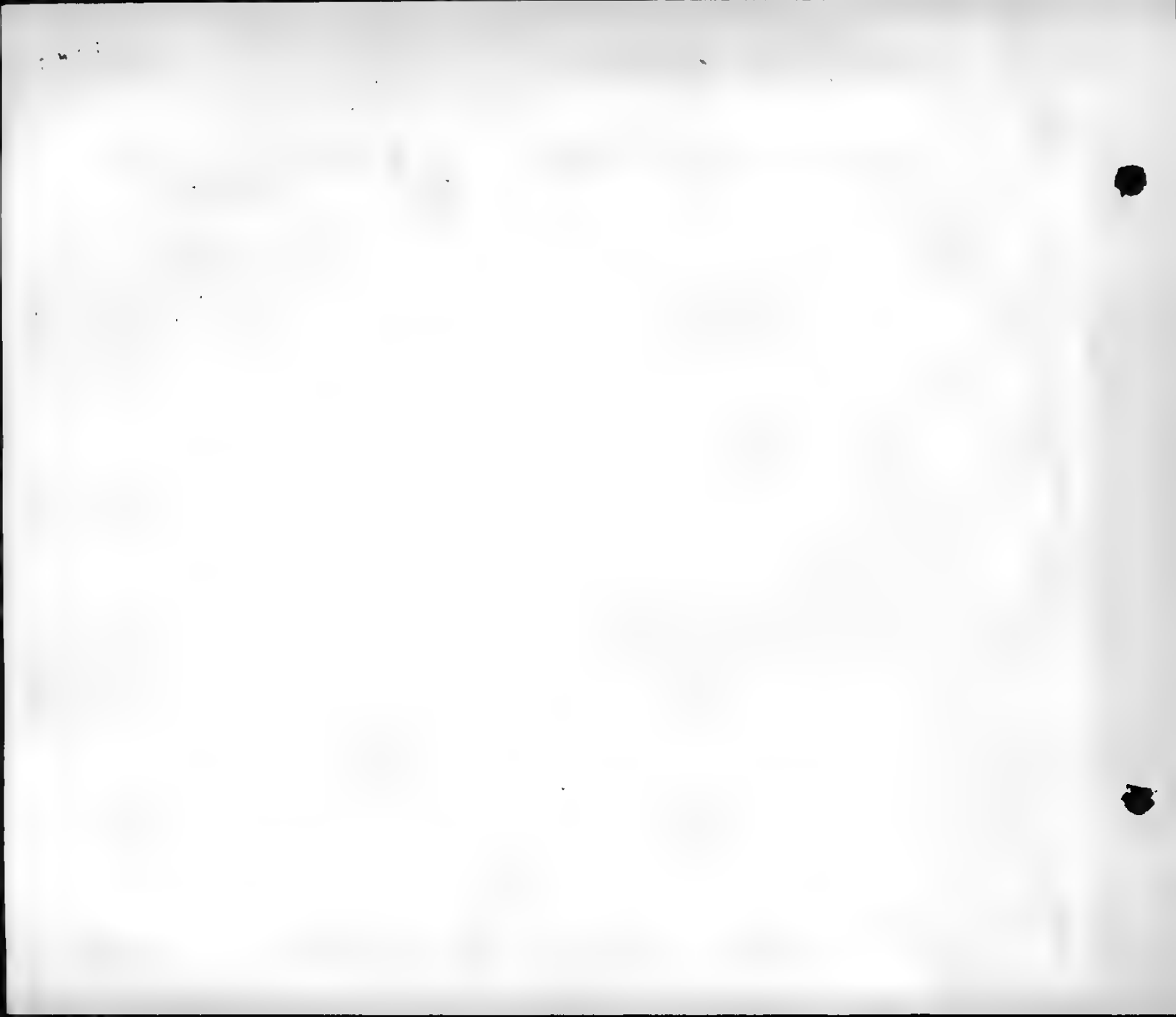
## CERTIFICATE OF DEATH

05336

Reg. Dist. No.

1. NAME OF DECEASED (Type or Print) <i>Ortho Summerslongh</i>			2. DATE OF DEATH <i>June 6/55</i>		
3. PLACE OF DEATH: A. Baltimore City—Maryland <i>College Park</i>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) B. STATE <i>4303 Falmouth Ave</i>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Co.</i> (If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside corporate limit, give the rural, and give township)		
c. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location)		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>—</i>	8. DATE OF BIRTH <i>April 6/1887</i>	9. AGE (In year—last birthday) <i>68</i>	10. Under 1 year Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State of foreign country) <i>Harover, Pa.</i>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <i>Philip Frebush</i>			14. MOTHER'S MAIDEN NAME <i>Michael Strauss</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <i>Carl Hemmuel</i>			18. ADDRESS <i>1101 71st Calvert St</i>		

I 199.9			CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			(A) <i>Islets intestinal hemorrhage</i>			24 hrs		
ANTECEDENT CAUSES			(B) <i>Carcinoma, site undetermined</i>			2 yrs -		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			(C) <i>Cerebral arteriosclerosis</i>			4 yrs -		
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)			21B. PLACE OF INJURY (e. g., is or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <i>Jan</i> , 1953, to <i>present</i> , 1955, that I last saw the deceased alive on <i>June 6</i> , 1955, and that death occurred at <i>12:30 pm</i> , from the causes and on the date stated above.								
23A. SIGNATURE <i>Emilio C. Brown Jr.</i>			23B. ADDRESS <i>1101 71st Calvert St</i>			23C. DATE SIGNED <i>June 6</i>		
24A. BURIAL, CREMATION, REMOVAL (Specify)			24B. DATE <i>June 7/55</i>			24C. NAME OF CEMETERY OR CREMATORY <i>Hebrew Franchises Cem.</i>		
24D. LOCATION (City, town, or county) <i>Balt. at Conklin St</i>			24E. DATE RECEIVED BY LOCAL REGISTRAR			24F. REGISTRAR'S SIGNATURE		
24G. FUNERAL DIRECTOR			24H. ADDRESS <i>243 Reisterstown Rd</i>			24I. SIGNATURE		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05337  
5341 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Balto.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <u>Lochearn</u>		OR TOWN <u>Lochearn</u>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>3807 Patterson Ave.</u>		<u>3807 Patterson Ave.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>GRACE R. HASTINGS</u>		OF DEATH: <u>June 30,</u> <u>1955</u>	
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>Aug. 18, 1874</u>
9. AGE last birthday: <u>80</u> yrs		10. BIRTHPLACE (State or foreign country): <u>Florida</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>at home</u>		12. CITIZEN OF WHAT COUNTRY: <u>Florida</u>	
13. FATHER'S NAME: <u>John Richardson</u>		14. MOTHER'S MAIDEN NAME: <u>Victoria Steele</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Grace E. Jones - 3807 Patterson Ave.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		<u>1 hr</u>	
<u>420.1</u>			
IMMEDIATE CAUSE			
ANTECEDENT CAUSE (S):			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST			
(A) <u>Myocardial infarction</u>			
(B) <u>Arteriosclerotic Hypertension Cardiovascular</u>			
(C) <u>diarrhea</u>		<u>many years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>7/2/55</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) (Minute)	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>11 April 1955</u> , to <u>24 June 1955</u> that I last saw the deceased alive on <u>24 June 1955</u> and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Dr. J. D. Davis</u>		DATE SIGNED <u>1 July 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7/2/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Lorraine Mausoleum</u>		LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>July 2, 1955</u>		REGISTRAR'S SIGNATURE <u>R.W.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Thos. J. Dickner &amp; Sons Balto</u>		ADDRESS <u>17</u>	

MARGIN RESERVE FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5342

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
52 TOWN <u>Catonsville</u>		OR TOWN <u>Catonsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1196 St. Agnes Lane</u>		STREET ADDRESS (If rural give location) <u>1196 St. Agnes Lane</u>	
3. NAME OF DECEASED: (Type or Print)		4. DATE (Month) (Day) (Year) OF DEATH	
(First) (Middle) (Last) <u>George W. Hine</u>		<u>June 5, 1955</u>	
5. SEX: <u>M.</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>July 31, 1883</u>
9. AGE last birthday <u>71</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired Gen. Elec. Corp.</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Ohio</u>	
11. BIRTHPLACE (State or foreign country): <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Charles L. Hine</u>		14. MOTHER'S MAIDEN NAME: <u>Melissa Anspaugh</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Y</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>315-07-7208 A</u>	
17. INFORMANT & ADDRESS: <u>Miss Ethel M. Hine, 1196 St. Agnes Lane</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Hypertensive Cardio-Vascular</u>			
ANTECEDENT CAUSE (B) <u>Renal Disease</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>55</u> , to <u>June 5</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4 June</u> , 19 <u>55</u> , and that death occurred at <u>300 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>W. H. Gatz</u>		ADDRESS <u>1707 Edmondson Ave. Catonsville, Md.</u>	
DATE SIGNED <u>6/5/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>June 6/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Edon, Ohio</u>		LOCATION (City, town, or county) (State) <u>Edon, Ohio</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6/5/55</u>		REGISTRAR'S SIGNATURE <u>V. E. Harry</u>	
24. FUNERAL DIRECTOR <u>Harry H. Witzke</u>		ADDRESS <u>4101 Edmondson Ave.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Wli. W. E. Du. Heath  
1303 Fredk. Rd. Cal.

5343

## CERTIFICATE OF DEATH

Reg. Dist. No.

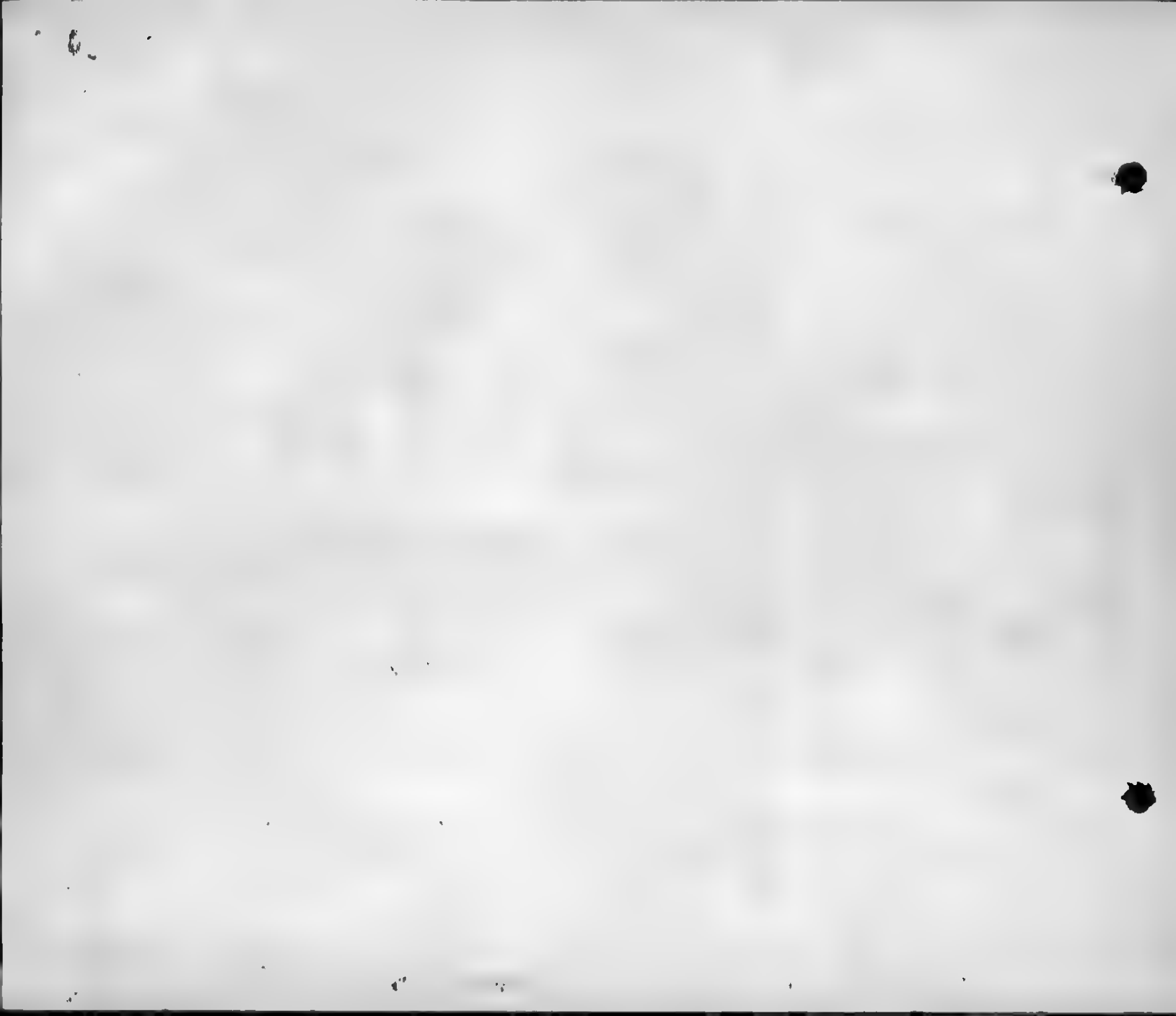
05339

2...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
52 TOWN <u>Catonsville</u>		3 yrs		52 TOWN <u>Catonsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6139 Regent Park Rd.</u>				STREET ADDRESS (If rural give location) <u>6139 Regent Park Rd.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <u>June 29 1955</u>			
<u>William E. Holmes</u>							
5. SEX: <u>M.</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Mar. 23, 1889</u>	9. AGE last birthday <u>66</u> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Stone Cutter</u>		<u>National Distillers.</u>		<u>England</u>		<u>U.S.A.</u>	
13. FATHER'S NAME: <u>William Holmes</u>				14. MOTHER'S MAIDEN NAME: <u>Harriett Wakeling</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-01-4285</u>		17. INFORMANT & ADDRESS: <u>Mrs Cora E. Holmes, 6139 Regent Pk, Rd.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>							
ANTECEDENT CAUSE (B) <u>Arterio Sclerotic Cardiovascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>(0168)</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Tuberculosis of Prostate</u>							
19A. DATE OF OPERATION: <u>6</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 19, 1946</u> to <u>June 29, 1955</u> , that I last saw the deceased alive on <u>June 28, 1955</u> , and that death occurred at <u>7:40 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Albert Scagnetta</u>		M. D. <u>1724 W Lombard St</u>		DATE SIGNED <u>July 1st 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 2/55</u>		NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		LOCATION (City, town or county) (State) <u>Baltimore, Maryland.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-1-55</u>		REGISTRAR'S SIGNATURE <u>H. W. Hedrick</u>		24. FUNERAL DIRECTOR <u>Harry H. Witzke</u>		ADDRESS <u>101 Edmondson Ave</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



5344

## CERTIFICATE OF DEATH

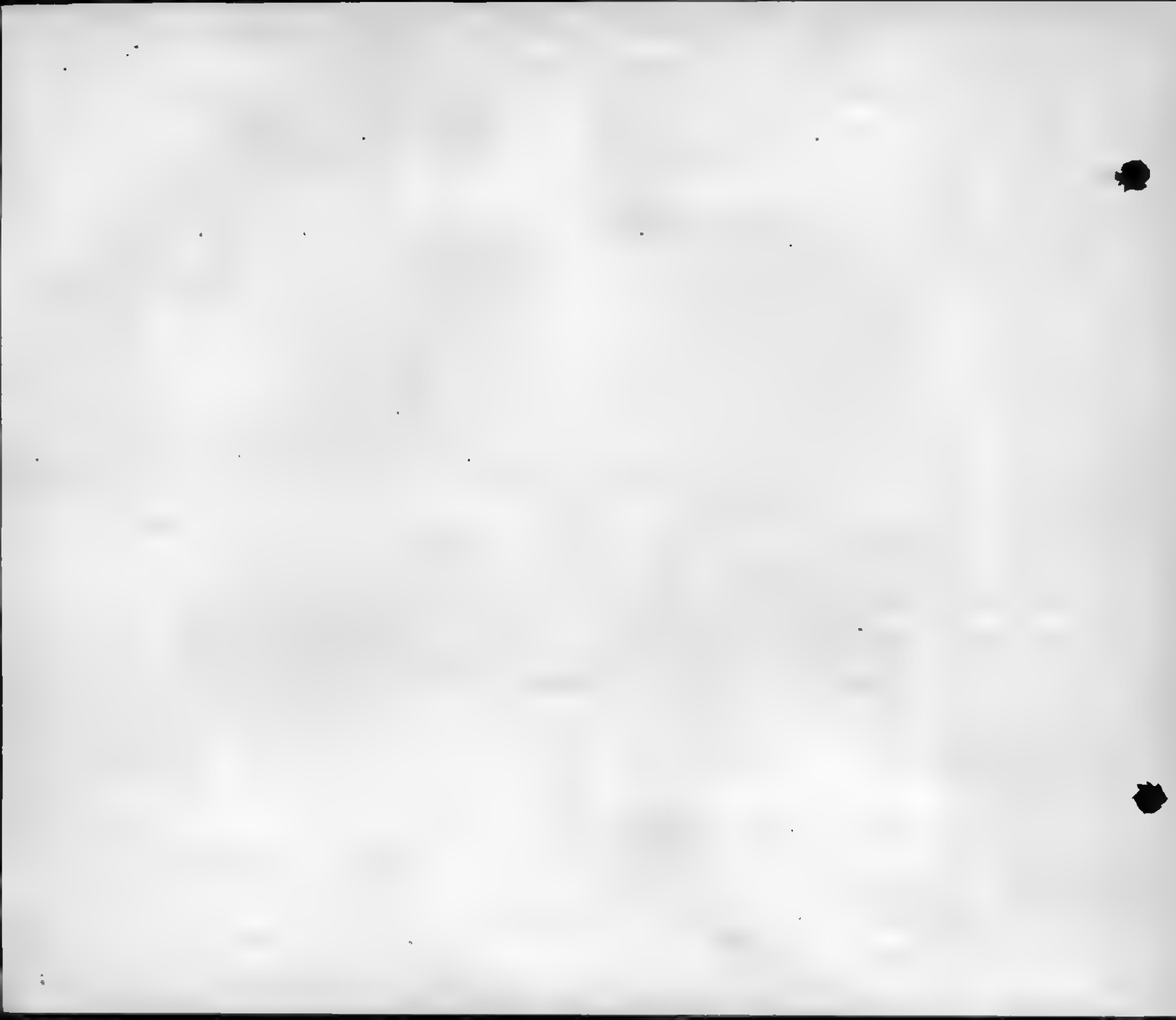
Reg. Dist. No.

05344

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY
CITY (If outside corporate limits, write RURAL or and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Armacost Nursing Home</u>		STREET ADDRESS (If rural give location)	
<u>90</u> <u>Regester Ave.</u>		<u>2201 St. Paul St.</u>	
3. NAME OF DECEASED: (Type or Print)		4. DATE (Month) (Day) (Year)	
(First) <u>L.</u>	(Middle) <u>ZAIDEE</u>	(Last) <u>HULME</u>	
5. SEX. <u>female</u>		6. DATE OF BIRTH: <u>June 8, 1870</u>	
6. COLOR OR RACE: <u>white</u>		7. AGE last birthday <u>85</u> yrs. Months Days Hours Min.	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>		8. DATE OF BIRTH: <u>June 8, 1870</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>never worked</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>--</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Thomas A. Hulme</u>		14. MOTHER'S MAIDEN NAME: <u>Hanna E. Campbell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unk) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT & ADDRESS: <u>Mr. J. C. H. deShields-2201 St. Paul St.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
4+3X IMMEDIATE CAUSE			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <u>Constitution heart failure</u>			
(B) <u>Hypertensive cardiac vascular disease</u>			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <u>July 3, 1933</u> to <u>June 15, 1955</u> , that I last saw the deceased alive on <u>June 15, 1955</u> , and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Marta L. Wise</u>		DATE SIGNED <u>6/16/55</u>	
M. D. <u>1120 St. Paul St.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/18/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Green Mount Cem.</u>		LOCATION (City, town, or county) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6-12-55</u>		REGISTRAR'S SIGNATURE <u>W. H. Hulme</u>	
FUNERAL DIRECTOR <u>Wm. J. Dickens &amp; Sons - Balt.</u>		ADDRESS <u>17</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5345				MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				05341			
Items 18421 Film G133 7-1-55 456								MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 33			
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:							
COUNTY Baltimore		MARYLAND		STATE Md.		COUNTY Baltimore					
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR							
TOWN Marriottsville				TOWN Marriottsville, Md.							
HOSPITAL OR INSTITUTION OR STREET ADDRESS Wards Chapel Road				STREET ADDRESS (If rural, give location) Wards Chapel Rd.							
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH		(Month) (Day) (Year)							
MILTON Charles HUMBLE		June 22, 1955									
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Divorced		8. DATE OF BIRTH: May 25, 1931		9. AGE last birthday: 24 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Employed by plumber		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME: Walter Humple				14. MOTHER'S MAIDEN NAME: Daisy Grimm							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No.: 218-26-8154		17. INFORMANT & ADDRESS: Daisy Humple, Marriottsville, Md.							
18. MEDICAL CERTIFICATION								INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:											
Immediate cause (a) Gunshot wound of head DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)											
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.											
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Home		21c. (City or town) (County) Marriottsville, Md.							
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 6/22/55 1:25 am.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Shot during altercation							
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
SIGNATURE R. Fisher				M. D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 6/22/55							
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF June 24, 1955		NAME OF CEMETERY OR CREMATORY Mt. Paran		LOCATION (City, town, or county) Baltimore County					
DATE REC'D BY LOCAL REG. 6-24-55		REGISTRAR'S SIGNATURE Mary B. Zline		24. FUNERAL DIRECTOR J.F. Eline & Sons, Reisterstown, Md.		ADDRESS					



5346

## CERTIFICATE OF DEATH

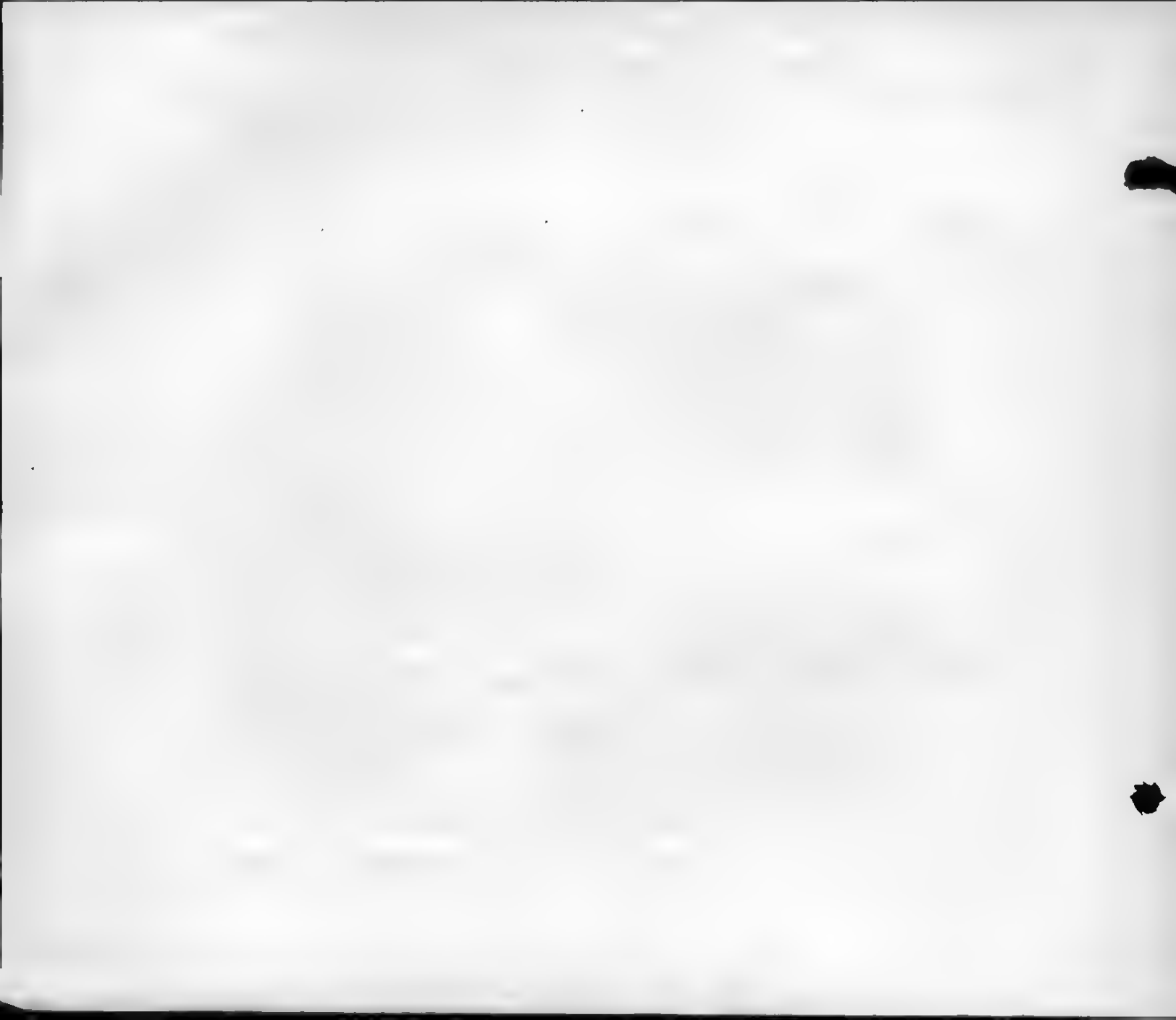
Reg. Dist. No.

05342

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>Armecost Nursing Home</u>		<u>Baltimore City</u>	<u>3401.4</u>
<u>812 Register Avenue</u>		<u>811 E. 34th Street</u>	
3. NAME OF DECEASED: (Type or Print)		4. DATE (Month) (Day) (Year)	
<u>Agnes Johnson</u>		OF DEATH: <u>6</u> <u>14</u> <u>1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>F</u>	<u>W</u>	<u>Married</u>	<u>March 3, 1878</u>
9. AGE last birthday		10. BIRTHPLACE (State or foreign country)	
<u>77</u> yrs.		<u>Howard County, Maryland</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>U.S.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Godfrey Ruff</u>		<u>Achsahbell?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>No</u>		<u>None</u>	
17. INFORMANT & ADDRESS:			
<u>Mr. George H. Johnson - 811 E. 34th St.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
422.1		<u>1 day</u>	
IMMEDIATE CAUSE		(A) <u>Cerebral Vascular Accident</u>	
ANTECEDENT CAUSE (S):		(B) <u>Arteriosclerotic Cardio-vascular Disease</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C) <u>Disease</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Mon</u> , 19 <u>47</u> , to <u>June</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>14 June, 1955</u> , and that death occurred at <u>8 P.</u> M. from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<u>Wm. H. Kammer Jr.</u>		<u>6/16/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>Harmony Grove Cemetery</u>	
DATE THEREOF		LOCATION (City, town, or county) (State)	
<u>6/17/55</u>		<u>Howard County, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR ADDRESS	
<u>6-15-55</u>		<u>Wm. J. Tucker &amp; Sons</u>	
REGISTRAR'S SIGNATURE		<u>Dr. Wm. H. Kammer Jr.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5347

05343  
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u>		MARYLAND		STATE		COUNTY	
CITY (If outside corporate limits, write RURAL OR give nearest town) <u>Essey</u>		LENGTH OF STAY (If this place) <u>28 yrs</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>Balto &amp; E</u>		<u>54</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1008 Essey ave</u>				STREET ADDRESS (If rural, give location) <u>1</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First) <u>Anna</u>		(Middle) <u>Marie</u>		(Last) <u>Jones</u>		(Month) <u>June</u> (Day) <u>15</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Widowed</u>	8. DATE OF BIRTH <u>Feb 21/1873</u>	9. AGE last birthday: <u>82</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Jacob Sigrist</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Haefner</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.):		16. SOCIAL SECURITY No.:		17. INFORMANT'S ADDRESS: <u>Lizetta Friedel (daughter)</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a) <u>chronic occlusion</u> DUE TO Antecedent cause(s) (b) <u>cardiovascular disease</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						<u>acute</u> <u>over 10 yrs</u>	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF DEATH <u>dark June 15 55 9:30 P.M.</u>				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>M. D. M. D.</u>				CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM.			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Buried</u>				DATE THEREOF: <u>6-16-1957</u>		NAME OF CEMETERY OR CREMATORY: <u>Holy Redeemer Cemetery</u>	
LOCATION: City, town, or county: <u>Balto Md</u>				(State):			
DATE REC'D BY LOCAL REG. <u>16 5:15</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>1407 Eastern Ave</u>	

2000

1000

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: Spring Grove State Hospital COUNTY Baltimore MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Catonsville LENGTH OF STAY (in this place) 16 days				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Baltimore CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Woodstock X STREET ADDRESS (If rural give location) Woodstock College			
3. NAME OF DECEASED: (Type or Print) John (First) (Middle) (Last) Keenan			4. DATE (Month) (Day) (Year) OF DEATH: 6 23 1955				
5. SEX: M	6. COLOR OR RACE: W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: 7-6-1877?	9. AGE last birthday 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dishwasher		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Washington	12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME: Unknown			14. MOTHER'S MAIDEN NAME: Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): Unknown (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT & ADDRESS: Records Spring Grove State Hospital			
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Terminal pneumonia					2 days		
ANTECEDENT CAUSE (B) Cardiopulmonic thrombosis					2 days		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Arteriosclerotic cardiovascular disease					Years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:			19B. MAJOR FINDINGS OF OPERATION				
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 6-6-1955 to 6-23-1955, that I last saw the deceased alive on 6-22-1955, and that death occurred at 4:25AM, from the causes and on the date stated above.							
SIGNATURE Stella Wachler		ADDRESS Spring Grove State		DATE SIGNED 6-23-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 6-25-55		NAME OF CEMETERY OR CREMATORY St. Alphonsus			
24. FUNERAL DIRECTOR		ADDRESS		25. DATE REC'D BY LOCAL REGISTRAR 6-24-55			
REGISTRAR'S SIGNATURE		REGISTRAR'S SIGNATURE		26. ADDRESS Eastons Catonsville, Md.			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



05345

## MARYLAND STATE DEPARTMENT OF HEALTH

5349

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 40

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>100 Mt. Vista Rd.</u>		STREET ADDRESS (If rural, give location) <u>100 Mt. Vista Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>John S. Killmeyer</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>21</u> (Year) <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>4-5-1911</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
13. FATHER'S NAME <u>John W. Killmeyer</u>		14. MOTHER'S MAIDEN NAME <u>Anna S. Killmeyer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT <u>John S. Killmeyer</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 Immediate cause <u>Coronary Infarction</u> Antecedent cause(s) <u>Angina pectoris</u> giving rise to the above cause stating the underlying cause last <u>Hypertensive Cardiovascular Dis.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 3/4 hrs</u> <u>2 1/2 hrs</u> <u>?</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing in the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE <u>Clifford F. Heason M.D.</u>		DATE SIGNED <u>6/21/58</u>	
23. BURIAL INFORMATION REMARKS (Specify) <u>Buried</u>		DATE THEREOF <u>6/24/58</u>	
NAME OF CEMETERY OR CREMATORY <u>Landon Park</u>		LOCATION (City, town, or county) (State) <u>Balto, Md.</u>	
DATE REC'D BY LOCAL REG. <u>6-22-58</u>		24. FUNERAL DIRECTOR <u>W. Cook Inc. 1217 St. Paul St.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17th. 18th. 19th.  
20th. 21st. 22nd.  
23rd. 24th. 25th.  
26th. 27th. 28th.  
29th. 30th. 31st.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05346

5350

## CERTIFICATE OF DEATH

Reg. Dist. No. XX

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTIMORE		MARYLAND		STATE MARYLAND		COUNTY	
CITY (If outside corporate limits, write RURAL, and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL, and give nearest town) OR TOWN BALTIMORE			
X TOWN FORT HOWARD		114 DAYS		STREET ADDRESS (If rural give location) 524 SOUTH BOND STREET			
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH: JUNE 4, 1955			
JOSEPH (NMI) KIMAWSKI							
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED	8. DATE OF BIRTH: 1-18-89	9. AGE last birthday: 66 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Grocerymen		10B. KIND OF BUSINESS OR INDUSTRY: Own		11. BIRTHPLACE (State or foreign country): Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: MICHAEL KIMAWSKI				14. MOTHER'S MAIDEN NAME: CATHERINE KIMAWSKE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): Yes (If Yes, give war or dates of service) WW 1				16. SOCIAL SECURITY NO.: 212-10-2051		17. INFORMANT & ADDRESS: Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
161X IMMEDIATE CAUSE (A) CARCINOMA OF LARYNX						1 1/2 Years	
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Feb. 10, 1955, to June 4, 1955, that I examined the deceased and that death occurred at 4:15 PM, from the causes and on the date stated above.							
SIGNATURE: WILLIAM B. VANDEGRIFT, M.D.				ADDRESS: VAH, Fort Howard, Md. DATE SIGNED: 6/5/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL		DATE THEREOF: June 8, 1955		NAME OF CEMETERY OR CREMATORY: BALTIMORE NATIONAL		LOCATION (City, town, or county) (State): BALTIMORE, MARYLAND	
DATE REC'D BY LOCAL REGISTRAR: 6-6-55		REGISTRAR'S SIGNATURE: H. W. Sedwick		FUNERAL HOME: William B. VanDegrift Inc. Funeral Home 6009 Harford Road, Baltimore, Md.			



5351

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTIMORE</u>	MARYLAND	STATE <u>MARYLAND</u>	COUNTY <u>BALTO.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>TOWSON</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>TOWSON</u>	55
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>ANNACREST NURSING HOME</u>		STREET ADDRESS (If rural give location) <u>5 MARYLAND AVE.</u>	1
3. NAME OF DECEASED: (First) (Middle) (Last)	4. DATE OF DEATH: (Month) (Day) (Year)		
<u>BERTHA ELIZABETH KING</u>	<u>JUNE 12 1955</u>		
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>5</u>	8. DATE OF BIRTH: <u>JAN. 27, 1879</u>
9. AGE last birthday: <u>76</u> yrs.		10. MONTHS <u>12</u> DAYS <u>19</u> HRS. <u>55</u> MIN.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>RET. NURSE</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>GENERAL NURSING</u>	
11. BIRTHPLACE (State or foreign country): <u>INDIANA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>EDWARD KING</u>		14. MOTHER'S MAIDEN NAME: <u>MARY EVANS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>NO</u>		16. SOCIAL SECURITY No.: <u>NONE</u>	
17. INFORMANT & ADDRESS: <u>JESSIE L. KING - TOWSON, MD.</u>			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Branch pneumonia</u>		<u>4 days</u>
Antecedent causes (s) (b) <u>Diabetes mellitus, generalized arteriosclerosis</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION: <u>8</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>Aug.</u> , 1953., to <u>present</u> , 1955., that I last saw the deceased alive on <u>11 Jan.</u> , 1955., and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above.		
SIGNATURE (Degree or title) <u>Ernest C. Brown M.D.</u>		DATE SIGNED <u>Jan 13, 1955</u>
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<u>BURIAL</u>	<u>JUN. 14, 1955</u>	<u>FRIENDS BURYING GROUND</u>
LOCATION (City, town, or county) (State)	<u>BALTIMORE, MD.</u>	
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR
<u>June 14, 1955</u>	<u>Mabel C. Gray</u>	ADDRESS <u>John Burns Lane, Towson, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U.S. POSTAGE



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05348

5352

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH. CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Catonsville				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Baltimore CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Grove State Hosp.				STREET ADDRESS (If rural give location) Hagerstown			
3. NAME OF DECEASED: (Type or Print) Reginald Nathaniel Knott				4. DATE OF DEATH: (Month) 6 (Day) 20 (Year) 1955			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: 12-5-1902	9. AGE last birthday: 52 yrs.	10. UNDER 1 YEAR: Months Days	11. UNDER 24 HRS.: Hours Min.	12. CITIZEN OF WHAT COUNTRY? USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miscellaneous				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Maryland	
13. FATHER'S NAME: Unknown				14. MOTHER'S MAIDEN NAME: Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): Unknown				16. SOCIAL SECURITY NO.: Unknown		17. INFORMANT & ADDRESS: Records Spring Grove State Hospital	
18. MEDICAL CERTIFICATION DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) Nodular cirrhosis of liver							Years
ANTECEDENT CAUSE (B) Chronic alcoholism							Years
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.							
19. DATE OF OPERATION: 7/6/55							20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?							
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY							21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>
21F. HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from 6-7-55, 1955, to 6-20-55, 1955 that I last saw the deceased alive on 6-25-55, 1955, and that death occurred at 6 A.M. from the causes and on the date stated above. SIGNATURE S. Wachler M.D. ADDRESS DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
7/6/55		7/6/55		Schlesinger Medical Baltimore Md.		Baltimore Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
JULY 7, 1955		S W Fournier		Mrs. Frances E. Fournier		87	

3 A 047207



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

05349

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md.</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Notch Cliff near Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Notch Cliff near Towson</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Villa Maria Glenarm Rd</u>		STREET ADDRESS <u>Glenarm Rd</u>	
3. NAME OF DECEASED (Type or Print) <u>Sister Mary Della Strada Knuth</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>25</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Dec 28 1887</u>
9. AGE last birthday <u>67</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Pechester N.Y.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Knuth</u>		14. MOTHER'S MAIDEN NAME <u>Johanna Frenderer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Sr. Mary Cpara Notch Cliff, Md.</u>			

18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause <u>Coronary Thrombosis</u>		(a) ...	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(b) ... <u>Arterio sclerosis</u>	
		(c) ...	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from May 3, 1953, to June 25, 1955, that I last saw the deceased

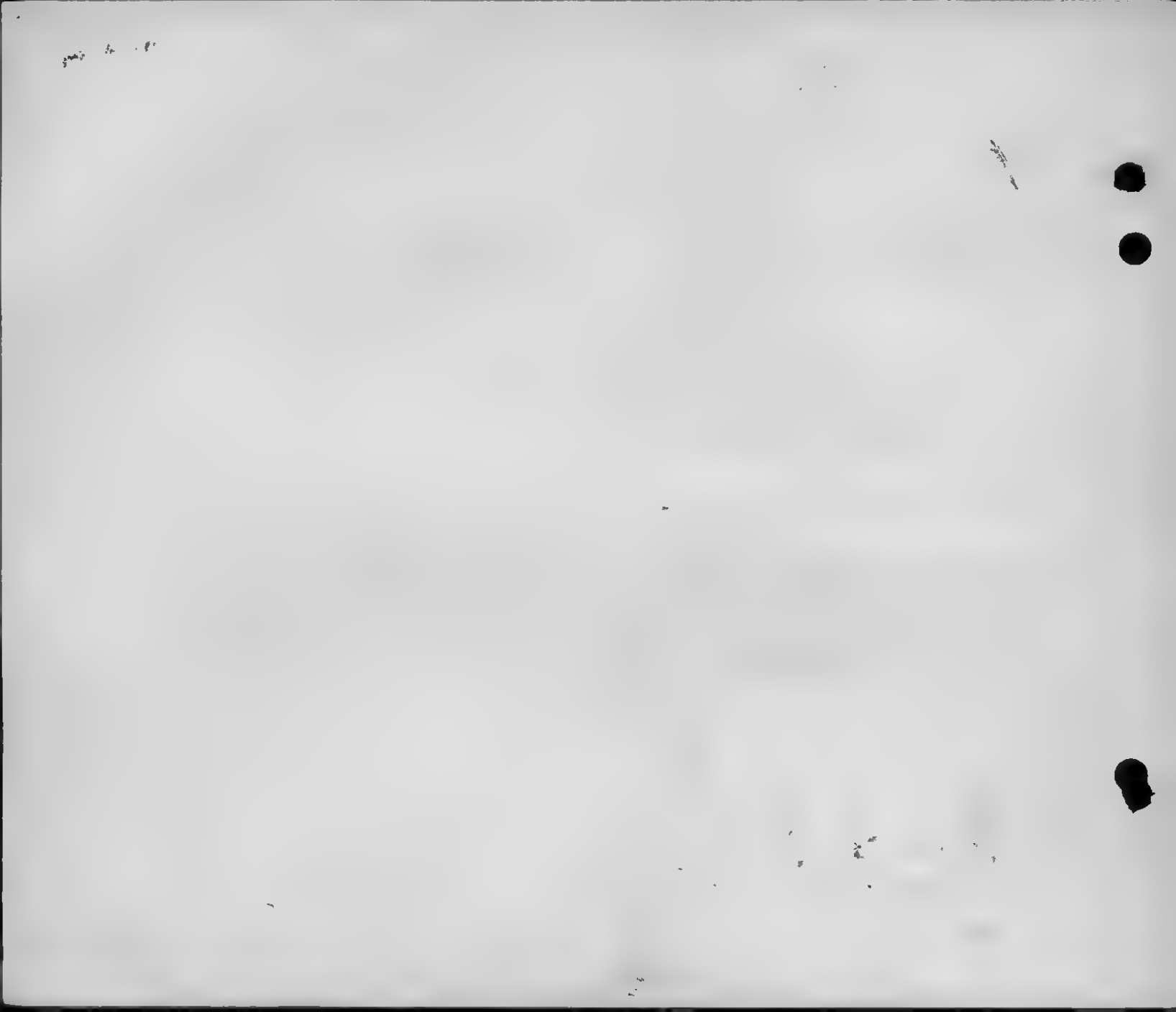
alive on June 21, 1955, and that death occurred at 5:45 A.M., from the causes and on the date stated above.

SIGNATURE Charles F. Donnell ADDRESS 7501 YORK RD. TOWSON, MD. DATE SIGNED 6/25/55

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>6-27-55</u>	<u>VILLA MARIA CEM.</u>	<u>NOTCH CLIFF NR TOWSON, MD.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>6-27-55</u>	<u>Chas. Hedrick</u>	<u>Charles S. Guler</u>	<u>901 S. CONKLING ST. BALTO., MD.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

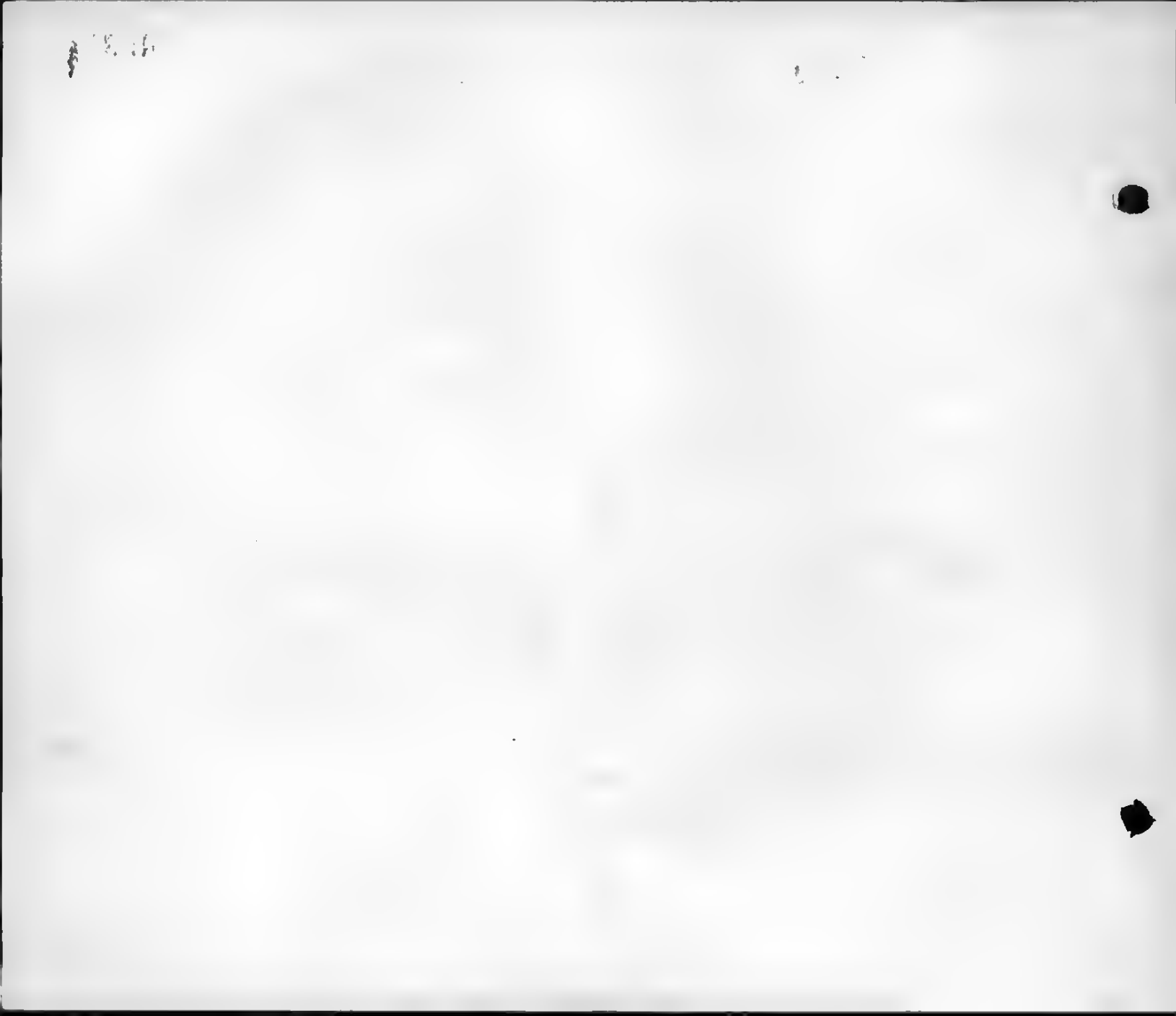
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05354

5354

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write OR and give nearest town) <u>52 Catonsville</u>		RURAL LENGTH OF STAY (in this place) <u>1 mo. 7 days</u>		CITY (If outside corporate limits, write OR and give nearest town) <u>02x2 Elvaton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove State Hospital</u>				STREET ADDRESS (If rural give location) <u>✓</u>			
3. NAME OF DECEASED: (First) <u>August</u> (Middle) <u>E.</u> (Last) <u>Kramer</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>June 13, 1955</u>			
5. SEX. <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>7-18-1880</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Cabinet Maker</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA ?</u>	
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hosp.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Arteriosclerotic gangrene, rt. foot</u>						<u>1 month</u>	
ANTECEDENT CAUSE (B) <u>Arteriosclerotic cardiovascular disease</u>						<u>Years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. <u>Generalized arteriosclerosis</u>						<u>Years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-6-</u> , 19 <u>55</u> to <u>6-13-</u> , 19 <u>55</u> that I last saw the deceased alive on <u>6-13-</u> , 19 <u>55</u> , and that death occurred at <u>1:15 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>G. Wachler</u>		M. D. <u>Catonsville</u>		ADDRESS <u>Spring Grove State Hospital</u>		DATE SIGNED <u>6-13-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 16, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>15-53</u>		REGISTRAR'S SIGNATURE <u>A.W. Hedrick</u>		24. FUNERAL DIRECTOR <u>Ulrich Funeral Home</u>		ADDRESS <u>4210 Belair Road.</u>	



5358 Item 9, File 1-2 6-10-55 at

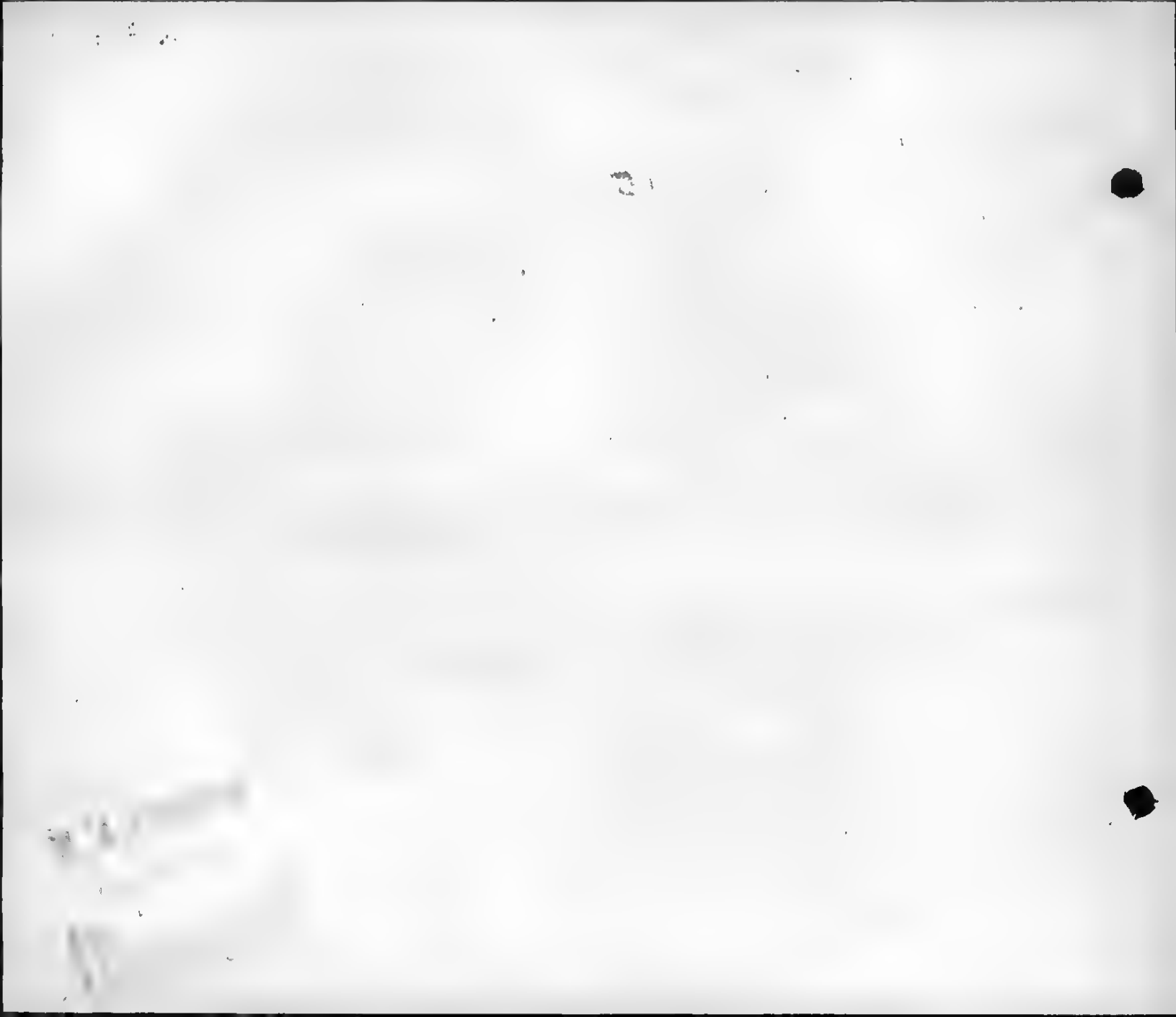
CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>		LENGTH OF STAY (in this place) <u>1 1/2 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>DAVIDSONVILLE 02X-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove Hospital</u>				STREET ADDRESS (If rural give location) <u>✓</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year)			
(First) <u>Lou</u> (Middle) <u>Emma</u> (Last) <u>Lambert</u>				DATE OF DEATH: <u>June 4</u> 19 <u>55</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>W</u>	8. DATE OF BIRTH: <u>9-17-1829</u>	9. AGE last birthday <u>76</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Mln.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>-</u>		11. BIRTHPLACE (State or foreign country): <u>Virginia</u>	
13. FATHER'S NAME: <u>Mat Cox</u>				14. MOTHER'S MAIDEN NAME: <u>Katherine King</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>✓</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.: <u>Unknown.</u>		17. INFORMANT'S ADDRESS: <u>Hospital Records</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>420.0</u>							
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Arteriosclerotic Ht. Disease</u>						<u>years</u>	
DUE TO							
(B) <u>Generalized Arteriosclerosis</u>						<u>years</u>	
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <u>Chronic Brain Syndrome</u>						<u>years</u>	
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>Feb 26, 1955</u> , to <u>June 4, 1955</u> , that I last saw the deceased alive on <u>June 4, 1955</u> , and that death occurred at <u>7:38 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Fredrick E Phillips</u>		M. D. <u>Spencer Green</u>		DATE SIGNED <u>6/4/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town or county) (State)	
<u>Buried</u>		<u>June 7/55</u>		<u>But Zion</u>		<u>Lolburn, Md</u>	
DATE REC'D BY LOCAL REGISTRAR: <u>6/4/55</u>		REGISTRAR'S SIGNATURE <u>V.E. Harris</u>		24. FUNERAL DIRECTOR <u>Benedict Harris</u>		ADDRESS <u>44 Calverly Rd</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



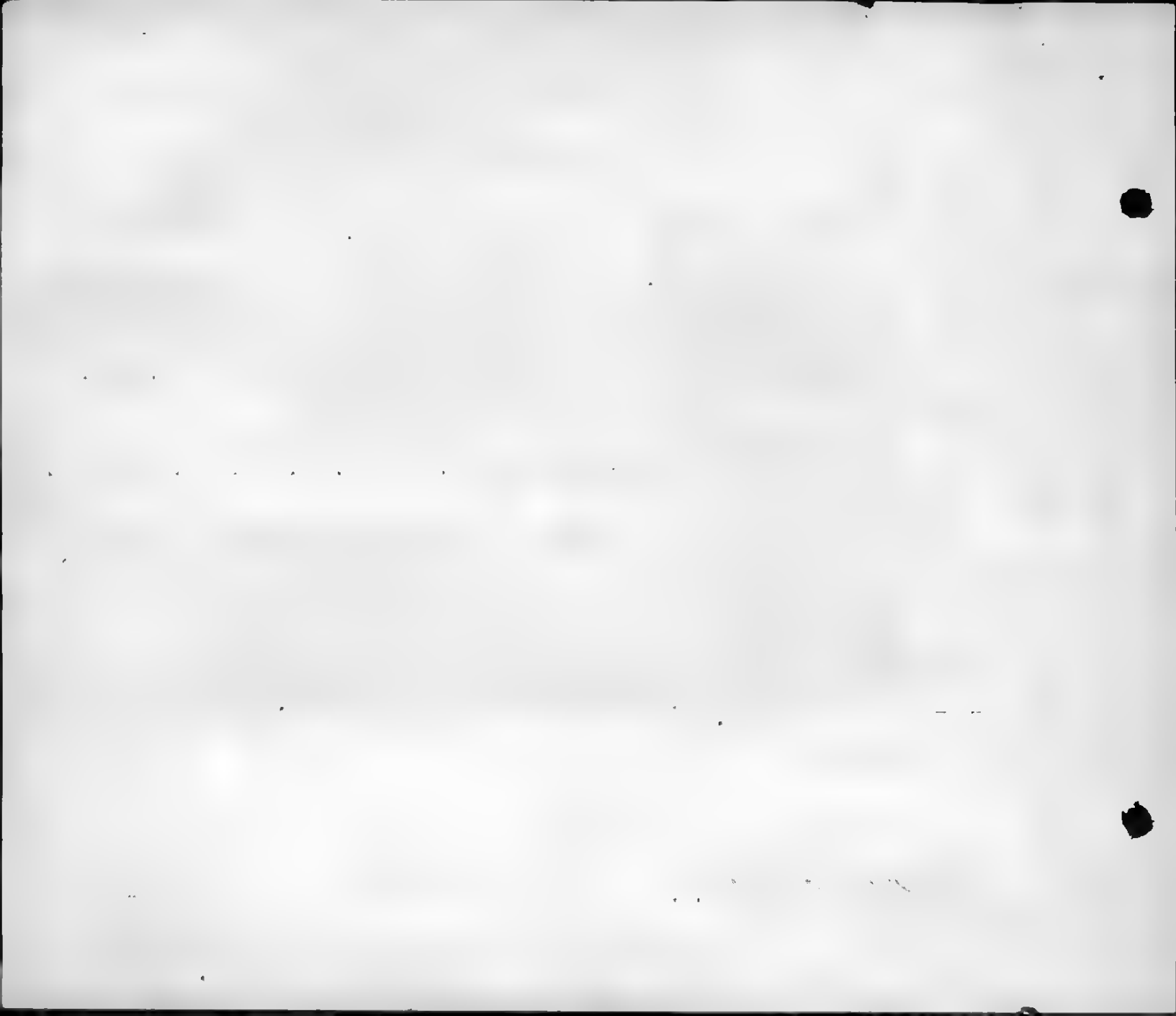
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 195352  
5356 CERTIFICATE OF DEATH

Reg. Dist. No. 46

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>BALTIMORE</b> CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <b>FORT HOWARD</b> HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>VETERANS ADMINISTRATION HOSPITAL</b>	MARYLAND LENGTH OF STAY (in this place) <b>94 DAYS</b>	STATE <b>MARYLAND</b> COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>BALTIMORE</b> STREET ADDRESS (If rural give location) <b>800 E. BALTIMORE STREET</b>	
3. NAME OF DECEASED: (Type or Print) <b>JOHN T. LANG</b>		4. DATE (Month) (Day) (Year) OF DEATH: <b>JUNE 30 1955</b>	
5. SEX: <b>MALE</b>	6. COLOR OR RACE: <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Specify): <b>WIDOWED</b>	8. DATE OF BIRTH: <b>6-30-88</b>
9. AGE last birthday: <b>67</b> yrs		10. AGE last birthday: <b>67</b> yrs	
11. BIRTHPLACE (State or foreign country): <b>BROOKLYN, NEW YORK</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME: <b>PHILIP LANG</b>		14. MOTHER'S MAIDEN NAME: <b>NANCY (UNKNOWN)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO. <b>104-03-5885</b>	
17. INFORMANT & ADDRESS: <b>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.</b>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>163X</b> IMMEDIATE CAUSE ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (A) <b>ABSCESSSES OF UPPER AND LOWER LOBES OF RIGHT LUNG</b> (B) <b>DOES NOT EXIST</b> (C)		<b>6 WEEKS</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>ABSENCE OF MIDDLE LOBE RIGHT LUNG (CARCINOMA)</b>			
19A. DATE OF OPERATION: <b>5-12-55</b>		19B. MAJOR FINDINGS OF OPERATION <b>Thoracotomy, right and right middle lobectomy. Carcinoma of lung.</b>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>MARCH 28 1955</b> , to <b>JUNE 30, 1955</b> , and that death occurred at <b>2:15 A.M.</b> from the causes and on the date stated above. SIGNATURE <b>WILLIAM B. VANDEGRIFT, M.D.</b> M.O. <b>VAH, FORT HOWARD, MARYLAND 7-1-55</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>REMOVAL</b>		DATE THEREOF <b>JULY 5, 1955</b>	
NAME OF CEMETERY OR CREMATORY <b>LONG ISLAND NATIONAL</b>		LOCATION (City, town, or county) (State) <b>LONG ISLAND, NEW YORK</b>	
DATE REC'D BY LOCAL REGISTRAR <b>JULY 5, 1955</b>		REGISTRAR'S SIGNATURE <b>WILLIAM COOK-BLIGHT INC.</b>	
SHIPPED TO: <b>315 Conklin St., Farmingdale, New York</b>		FURNERAL DIRECTOR ADDRESS <b>6009 HARFORD RD BALTIMORE, MD</b>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



5357

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

Reg. Dist. No. ....

1. PLACE OF DEATH - COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>MD</u> COUNTY <u>10</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>None</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
TOWN <u>None</u>		TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Beth. Steel Dispensary</u>		STREET ADDRESS (If rural, give location) <u>901 J Street</u>	
3. NAME OF DECEASED (First) <u>LASHLEY</u> (Middle) <u>TEN</u> (Last) <u>SEN</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>3</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Black</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept. 18, 1897</u>
9. AGE last birthday <u>56</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Warren City, N. C.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Lashley</u>		14. MOTHER'S MAIDEN NAME <u>Martha Sullivan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>World War I</u>		16. SOCIAL SECURITY No. <u>618981</u>	
17. INFORMANT AND ADDRESS <u>Left Lashley 618981</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

024X  
 Immediate cause

(a) Luetic Cardio-Vascular Disease with

Antecedent cause(s)  
 Diseases or conditions, if any,  
 giving rise to the above cause  
 stating the underlying cause last

(b) Luetic AORTITIS

(c) Luetic Neurosyphilis

INTERVAL BETWEEN ONSET AND DEATH

? -

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05354

5358

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Balto.</u>
CITY (If outside corporate limits, write RURAL; OR and give nearest town) <u>52</u> TOWN <u>Catonsville</u>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>52</u> <u>Catonsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>638 Aldershot Rd.</u>		STREET ADDRESS (If rural give location) <u>638 Aldershot Rd.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>DELLA FRANCES LEAKE</u>		DEATH: <u>June 24 19 55</u>	
5. SEX. <u>Female</u>	6. COLOR OR RACE. <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Widowed</u>	8. DATE OF BIRTH <u>Feb. 14, 1881</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>at home</u>	9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS. <u>74</u> yrs Months Days Hours Min.
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>William Cramblitt</u>		14. MOTHER'S MAIDEN NAME: <u>Adeline Sweitzer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT & ADDRESS: <u>Mr. Charles J. Leake-638 Aldershot Rd.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		<u>2 yrs.</u>	
IMMEDIATE CAUSE <u>420.1</u> (A) <u>Coronary Occlusion</u> DUE TO			
ANTECEDENT CAUSE (S):			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(B) DUE TO			
(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory OR INJURY street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 24, 1953</u> , to <u>June 24, 1953</u> , that I last saw the deceased alive on <u>June 24, 1953</u> , and that death occurred at <u>5:00</u> A.M. from the causes and on the date stated above.			
SIGNATURE <u>A.P. Van Schuerbeek</u>		ADDRESS <u>M.D. 4618 Edmondson Ave</u> DATE SIGNED <u>6/25/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>6/27/55</u>	NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>	LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
DATE REC'D BY LOCAL REGISTRAR <u>6-25-55</u>	REGISTRAR'S SIGNATURE <u>RW</u>	24. FUNERAL DIRECTOR <u>Wm. J. Dickener</u>	ADDRESS <u>Sou. Balto 17 A</u>



**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-53 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5359

## CERTIFICATE OF DEATH

05355

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		STATE <u>MARYLAND</u>		COUNTY <u>ANNE ARUNDEL</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>52 CATONSVILLE</u>		LENGTH OF STAY (in this place) <u>7 WKS 3 DAYS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>LINTHICUM</u>		<u>22X 2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>70 HOME IN THE PINES</u>				STREET ADDRESS (If rural give location) <u>437 KINGWOOD ROAD</u> ✓			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>ANNIE ELIZABETH LEGGETTE</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JUNE 4 1955</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>JAN 17, 1874</u>	9. AGE last birthday <u>81</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWOMAN (RETD)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>WINDSOR, N. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>DOCTOR WILLIAMS</u>				14. MOTHER'S MAIDEN NAME <u>SARAH E. BAZEMORE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>JACKSON L. LEGGETTE</u>		<u>437 KINGWOOD RD LINTHICUM</u>	
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN FID ONSET AND DEATH	
170X IMMEDIATE CAUSE (A) <u>Cancer of Breast.</u>						<u>6 hrs -</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Metastasis to Spleen</u>						<u>2-3 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Organs -</u>							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>8</u>		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/4</u> , 19 <u>54</u> , to <u>6/4</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6/4</u> , 19 <u>55</u> , and that death occurred at <u>4:30</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Chas - L. Ball</u>				ADDRESS (Street, city, town, state) <u>P. Linthicum</u>		DATE SIGNED <u>6/6/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>JUNE 7, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>GLEN HAVEN</u>		LOCATION (City, town, or county) (State) <u>GLEN BURNIE MD</u>	
24. REC'D BY REGISTRAR <u>June 10, 1955</u>		REGISTRAR'S SIGNATURE <u>Victor E. Harris</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas W. Angleton</u>		ADDRESS <u>Glen Burnie Md</u>	

THE

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THE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5360 CERTIFICATE OF DEATH

05356

Reg. Dist. No. 33

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Baltimore</b>		MARYLAND		STATE <b>Maryland</b> COUNTY <b>Montgomery</b>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <b>Owings Mills</b>		6 mo.		TOWN <b>Kensington</b>		15X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Rosewood State Training School</b>				STREET ADDRESS (If rural, give location) <b>10118 Thornwood Road</b>			
3. NAME OF DECEASED: (First) <b>Kathryn</b>		(Middle) <b>Lee</b>		(Last) <b>Levedahl</b>		4. DATE OF DEATH: (Month) <b>6</b> (Day) <b>21</b> (Year) <b>19 55</b>	
5. SEX: <b>female</b>		6. COLOR OR RACE: <b>white</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>single</b>		8. DATE OF BIRTH: <b>3/12/53</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday: <b>2</b> yrs.		11. BIRTHPLACE (State or foreign country): <b>Washington, D.C.</b>	
						12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>William John Levedahl</b>				14. MOTHER'S MAIDEN NAME: <b>Charmian Scates</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <b>Rosewood Records</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
351X Immediate cause (a) <b>Status Epilepticus</b>							
DUE TO <b>Injury of head-birth with symptomatic epilepsy and Left hemoplegia (pneumoencephalogram-ventricular system dilated bilaterally and symmetrically. Some degree of cortical atrophy</b>						Birth	
Antecedent cause(s) (b) <b>over both hemispheres.</b>							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <b>over both hemispheres.</b>							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:						20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE		INJURY					
HOMICIDE							
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED While at Not while M. work <input type="checkbox"/> at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
OF INJURY							
22. I hereby certify that I attended the deceased from <b>9/16</b> , 19 <b>53</b> , to <b>6/21</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>6/21</b> , 19 <b>55</b> , and that death occurred at <b>8:30 a.m.</b> , from the causes and on the date stated above.							
SIGNATURE		(DEGREE OR TITLE)		ADDRESS		DATE SIGNED	
<b>M.B. Byler MD</b>				<b>Owings Mills, Maryland</b>		<b>6/21/55</b>	
23. BURIAL, CREMATION REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Cremation</b>		<b>June 21, 1955</b>		<b>Green Mount Crematory</b>		<b>Baltimore, Md.</b>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<b>6-21-55</b>		<b>Mary B. Eline</b>		<b>J.F. Eline &amp; Sons, Reisterstown, Md.</b>			

U.S. AIR FORCE

NOF

11

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

5275

## CERTIFICATE OF DEATH

05357

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>		
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> <u>Baltimore</u>			CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> <u>Baltimore</u>		
TOWN <u>Baltimore</u>			TOWN <u>Baltimore</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3539 McShane Way</u>			STREET ADDRESS (If rural, give location) <u>3539 McShane Way</u>		
3. NAME OF DECEASED (Type or Print)		(First)	(Middle)	(Last)	4. DATE OF DEATH
		<u>Joseph</u>	<u>Stanley</u>	<u>Lewandowski</u>	<u>June 7th, 1955</u> 19
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	10. If under 1 year
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Dec. 8-1913</u>	<u>41</u> yrs.	Months Days Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Beth. Steel Co.</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore - Maryland</u>	
13. FATHER'S NAME <u>Ignatius Lewandowski</u>			14. MOTHER'S MAIDEN NAME <u>Mary</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY No. <u>216-10-4743</u>		17. INFORMANT AND ADDRESS <u>Mrs. Helen Lewandowski - 3539 McShane Way</u>

### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Coronary Thrombosis

INTERVAL BETWEEN ONSET AND DEATH

2 months

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Coronary arteriosclerosis

unknown

### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
	INJURY			
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from April, 1955, to June, 1955, that I last saw the deceased

alive on 4 June, 1955, and that death occurred at 8:15 p.m., from the causes and on the date stated above.

SIGNATURE B. W. DeLoach M.D. 2900 Dunbar Rd Dundalk Md 8 June 1955 ADDRESS DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Buried</u>	<u>June 11-1955</u>	<u>St. Stanislaus</u>	<u>1300 Dundalk ave</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>6-8-55</u>	<u>George A. Weber</u>	<u>George A. Weber</u>	<u>705 S. Ann St</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Items 184-21-184 7-20-55  
 5361  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 Item 7, Film 183 7-6-55 st

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05358

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Montgomery	
CITY (If outside corporate limits write RURAL OR and give nearest town) <i>Ruxton</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Bethesda		15x	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) 5504 Nelson Road			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) GEORGE (Middle) WALSON (Last) LIGON				(Month) June (Day) 30 (Year) 1955			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH: Nov. 26, 1921	9. AGE last birthday: 33 yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Owner-John Ligon, Inc.			10b. KIND OF BUSINESS OR INDUSTRY: Floor tile & Fixtures		11. BIRTHPLACE (State or foreign country): Washington, D.C.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John F. Ligon, Sr.				14. MOTHER'S MAIDEN NAME: Veryl Walson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.: 579-18-4740		17. INFORMANT & ADDRESS: Wife-5504 Nelson Road			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) ... Crushing injury of head							
Antecedent cause(s) (b) ...							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office, bldg., etc.) OF INJURY Bridge		21c. (City or town) Ruxton (County) Balto. (State) Md.			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 6/30/55 2:45 P.M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Jumped from bridge			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <i>Paul V. Men</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7/1/55	
23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL		DATE THEREOF July 2-1955		NAME OF CEMETERY OR CREMATORY PARK LAWN		LOCATION (City, town, or county) Montgomery Co. (State) Md.	
DATE REC'D BY LOCAL REG. 1-55		REGISTRAR'S SIGNATURE <i>P.W. Hedgick</i>		24. FUNERAL DIRECTOR <i>Wm. J. Tickner &amp; Sons</i>		ADDRESS No. 4 Pa. Aves. 17th St.	



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5362 CERTIFICATE OF DEATH

05359

Reg. Dist. No. 32

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Catonsville</u>		<u>45 yrs.</u>		TOWN <u>Catonsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>102 Delrey Ave.</u>				STREET ADDRESS (If rural, give location) <u>102 Delrey Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>FREDERICK WIESSNER LIPPS</u>				<u>June 29, 19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>married</u>	<u>Sept. 18, 1900</u>	<u>54 yrs</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Builder</u>		<u>Contracting Business</u>		<u>Baltimore, Maryland</u>		<u>U. S.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Frederick Lipps</u>				<u>Anna Elizabeth Wiessner</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>Und.</u>				<u>Mrs. Carvilla Helfrich Lipps 102 Delrey Ave.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Pulmonary Emboli</u>						<u>2 hrs.</u>	
Antecedent cause(s) (b) <u>Cirrhosis - Hepatomegaly</u>						<u>8 years.</u>	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Bronchitis</u>						<u>57 years.</u>	
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:						19b. MAJOR FINDINGS OF OPERATION:	
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
<u>SUICIDE</u>		<u>OF INJURY</u>		<u></u>		<u></u>	
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED		HOW DID INJURY OCCUR?			
<u>OF INJURY</u>		<u>M. While at work</u>		<u></u>			
22. I hereby certify that I attended the deceased from <u>May 19, 1955</u> , to <u>6/29/55</u> , that I last saw the deceased alive on <u>June 28, 1955</u> , and that death occurred at <u>11:15 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Wetherbee Fort</u>				(DEGREE OR TITLE) <u>1118 St. Paul St.</u>		DATE SIGNED <u>June 30, 1955</u>	
23. BURIAL, CREMATION REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>July 1, 1955</u>		<u>Louden Park Cemetery</u>		<u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REG.		REGISTER'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>30-55</u>		<u>W. Wetherbee Fort</u>		<u>John O. Mitchell &amp; Sons Inc.,</u>		<u>1900 Eutaw Pl.</u>	



5363

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X</u> TOWN <u>Cockeysville</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> <u>3101.4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u> <u>5 McCann Ave.</u>		STREET ADDRESS (If rural give location) <u>3820 Tudor Arms Ave.</u> ✓	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>LILLIE</u> <u>M. A.</u> <u>LYNCH</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>June 16,</u> <u>19 55</u>	
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>	8. DATE OF BIRTH: <u>June 19, 1882</u>
9. AGE last birthday: <u>72</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Mln. IF UNDER 24 Hrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>(retired) saleslady</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Department Store</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>-- Lynch</u>		14. MOTHER'S MAIDEN NAME: <u>Margaret McDonough</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Mr. R. L. Rapp - 215 N. Charles St.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
2. I hereby certify that I attended the deceased from <u>3/4</u> , 19 <u>54</u> , to <u>6/16</u> , 19 <u>55</u> that I last saw the deceased alive on <u>6/16</u> , 19 <u>55</u> , and that death occurred at <u>1:10 PM</u> from the causes and on the date stated above.			
SIGNATURE <u>Beauett A. Stearns</u>		ADDRESS <u>M. D. Sutheraville</u>	
DATE SIGNED <u>6/16/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/20/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Green Mount Cem.</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>June 18, 1955</u>		REGISTRAR'S SIGNATURE <u>R.W.</u>	
24. FUNERAL DIRECTOR <u>Wm. J. Dickner &amp; Sons</u>		ADDRESS <u>Baltimore, Md.</u>	

MARGIN RESERVE FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Item 9, Film 184 7-28-55 et

5281

## CERTIFICATE OF DEATH

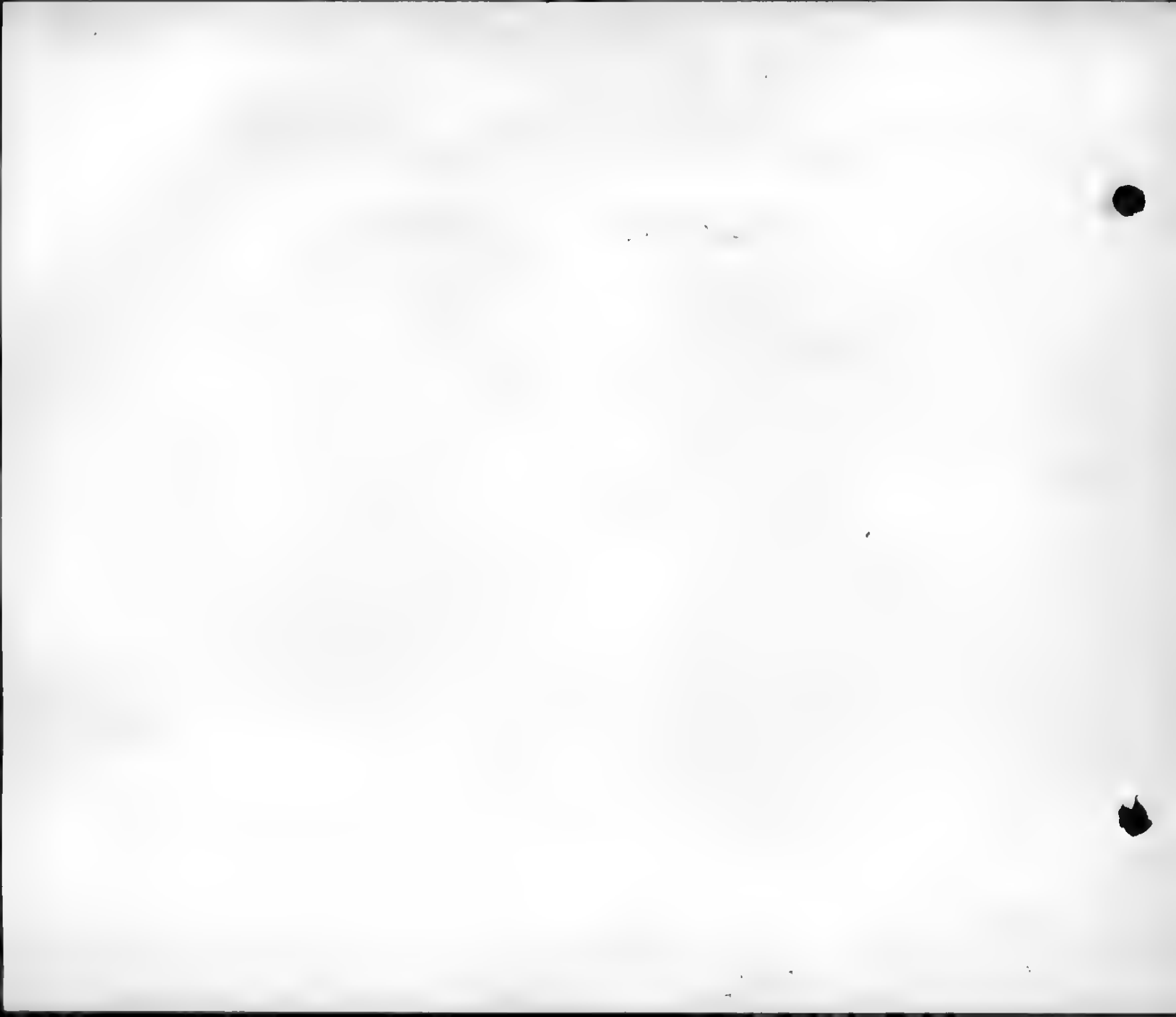
Reg. Dist. No. ....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
TOWN <u>HALETHORPE</u>		<u>55 YRS</u>		TOWN <u>HALETHORPE</u>		<u>51</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5720 FIRST AVE.</u>				STREET ADDRESS (If rural give location) <u>5720 FIRST AVE.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>THOMAS F LYONS</u>				<u>JUNE 13 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
<u>MALE</u>	<u>WHITE</u>	<u>WIDOWED</u>	<u>OCT. 6, 1878</u>	<u>76 7/11</u> yrs.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>NIGHTWATCHMAN BALTO. NAT. BANK</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>IRELAND</u>	
13. FATHER'S NAME: <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME: <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>216-14-1778A</u>		17. INFORMANT & ADDRESS: <u>ANNA M. WOLF 5720 FIRST AVE</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Hypertensive ASCVD</u>							
ANTECEDENT CAUSE (B) <u>Coronary Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>Diabetes Mellitus</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/1</u> , 1955, to <u>6/13</u> , 1955, that I last saw the deceased alive on <u>6/11</u> , 1955, and that death occurred at <u>11:05</u> AM, from the causes and on the date stated above.							
SIGNATURE <u>John C. Healy</u>				ADDRESS <u>M. D. Halethorpe, Md</u>		DATE SIGNED <u>6/13/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>JUNE 16, 1955</u>		<u>NEW CATHEDRAL</u>		<u>BALTIMORE, MARYLAND</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>6-14-55</u>		<u>John C. Healy</u>		<u>Joseph J. Ambrose, Jr.</u>		<u>1328 Sulphur Sp. Rd.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5364

05362  
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 33

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Ind.</u>		COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
X TOWN <u>Cockeysville</u>		<u>16 yrs.</u>		TOWN <u>Cockeysville</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Falls Rd.</u>				STREET ADDRESS (If rural, give location) <u>Cuba Rd.</u>			
3. NAME OF DECEASED: (Type or Print) <u>HARRY VICTOR MADDEN</u>				4. DATE OF DEATH <u>June 4 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>Colored</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>Sept 28 '02</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Farm</u>		9. AGE last birthday: <u>52</u> yrs.		11. BIRTHPLACE (State or foreign country): <u>Balto Co. Ind.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>W. S. Ind.</u>				13. FATHER'S NAME: <u>Harry E. Madden</u>			
14. MOTHER'S MAIDEN NAME: <u>Effie Whitaker</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No.</u>			
16. SOCIAL SECURITY No.: <u>None</u>				17. INFORMANT & ADDRESS: <u>Connie Cole Madden</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<u>9/2.1</u> Immediate cause (a) <u>Crushed left chest.</u> DUE TO <u>apoplexy</u> Antecedent cause(s) (b) <u>Internal hemorrhage</u> Diseases or conditions, if any, giving rise to the above cause DUE TO <u>Tractor upset on him.</u> stating underlying cause last (c)						<u>15 min.</u>  <u>15 min.</u>  <u>15 min.</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u>							
19a. DATE OF OPERATION: <u>None</u>				19b. MAJOR FINDING OF OPERATION: <u>None</u>			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Farm.</u>		21c. (City or town) <u>Butler</u> (County) <u>Balto.</u> (State) <u>Ind.</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>June 4 '55 5 M.</u>		21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Tractor upset on him.</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>D. D. Caples</u>				M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> DATE SIGNED <u>June 4 '55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>6-8-55</u>		NAME OF CEMETERY OR CREMATORY <u>Doughs Methodist</u>		LOCATION (City, town, or county) (State) <u>Cockeysville Ind.</u>	
DATE REC'D BY LOCAL REG. <u>6-7-55</u>		REGISTRAR'S SIGNATURE <u>Mary B. Stine</u>		24. FUNERAL DIRECTOR <u>Dee Dee Funeral Service, Spiceland</u> ADDRESS			

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05363

5365

## CERTIFICATE OF DEATH

Reg. Dist. No. 3

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Balto</i>	MARYLAND	STATE <i>Md</i>	COUNTY <i>Anne Arundel</i>
CITY (If outside corporate limits, write RURAL and give nearest town) <i>52 Catonsville</i>	LENGTH OF STAY (in this place) <i>4 mo</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>02X-2</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>14 Spring Grove Hospital</i>		STREET ADDRESS (If rural give location) <i>RFD 2 Box 336 Annapolis</i>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<i>MOSES RULON MANKIN</i>		<i>6 28 19 55</i>	
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Widower</i>	8. DATE OF BIRTH: <i>March 19, 1869</i>
9. AGE last birthday <i>86</i> yrs		10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Gardener</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Flowers</i>	11. BIRTHPLACE (State or foreign country): <i>Pennsylvania, U.S.A.</i>
13. FATHER'S NAME: <i>Moses R. Mankin</i>		12. CITIZEN OF WHAT COUNTRY: <i>U.S.A.</i>	
14. MOTHER'S MAIDEN NAME: <i>UNK</i>		17. INFORMANT & ADDRESS: <i>Mrs Anna Riley, RFD 2 Box 336 Annapolis Rd, Md.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO.	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
490X IMMEDIATE CAUSE (A) <i>Right lobar Pneumonia</i>			
ANTECEDENT CAUSE (B) <i>Serulity &amp; Dehydration</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i>Generalized Arteriosclerosis</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <i>6/20</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>3/15</i> , 1955, to <i>6/20</i> , 1955, that I last saw the deceased alive on <i>6/20</i> , 1955, and that death occurred at <i>4 AM</i> , from the causes and on the date stated above.			
SIGNATURE <i>(Spring Grove Hospital) H.R. Cowen</i>		DATE SIGNED <i>6/20/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		NAME OF CEMETERY OR CREMATORY <i>CEDAR Bluff</i>	
DATE THEREOF <i>6/30/55</i>		LOCATION (City, town, or county) <i>Annapolis Md</i>	
DATE REC'D BY LOCAL REGISTRAR <i>June 28, 1955</i>		REGISTRAR'S SIGNATURE <i>Victor E. Henry</i>	
24. FUNERAL DIRECTOR <i>Hollam Taylor &amp; Sons</i>		ADDRESS <i>Annapolis, Md.</i>	

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100-1000000

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05964

5366

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Baltimore</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>Tiara</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Rockyville</i>	LENGTH OF STAY (In this place) <i>2 1/2 months</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Easton Md</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Masonic Home</i>	STREET ADDRESS (If rural give location) <i>407 Goldsborough St</i>		
3. NAME OF DECEASED: (First) (Middle) (Last) <i>Robert Henry Marvel</i>		4. DATE (Month) (Day) (Year) OF DEATH: <i>June 15 1955</i>	
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH: <i>March 10 - 1873</i>
9. AGE last birthday: <i>82</i> yrs.		IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Engineer &amp; Farmer</i>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <i>Easton Md</i>
13. FATHER'S NAME: <i>George W. Marvel</i>		14. MOTHER'S MAIDEN NAME: <i>Cotilia Stewart</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk. If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <i>Laura M. Schneider</i>	
16. SOCIAL SECURITY NO.: <i>None</i>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <i>Acute Congestive</i>		<i>over 2 wks</i>	
ANTECEDENT CAUSE (B) <i>heart failure</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>4/5</i> , 1955, to <i>6/15</i> , 1955 that I last saw the deceased alive on <i>June 15, 1955</i> , and that death occurred at <i>9:50 PM</i> , from the causes and on the date stated above.			
SIGNATURE <i>Walter T. Kus</i>		DATE SIGNED <i>6/5 55</i>	
M. D. <i>Cockeysville Md</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<i>June 18/55</i>		<i>Stevensville Queens Ann Co.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>June 20, 1955</i>		24. FUNERAL DIRECTOR ADDRESS <i>Wm. Cook, St. Paul &amp; Creston St</i>	

BUREAU V. E.

1955

1955

5367

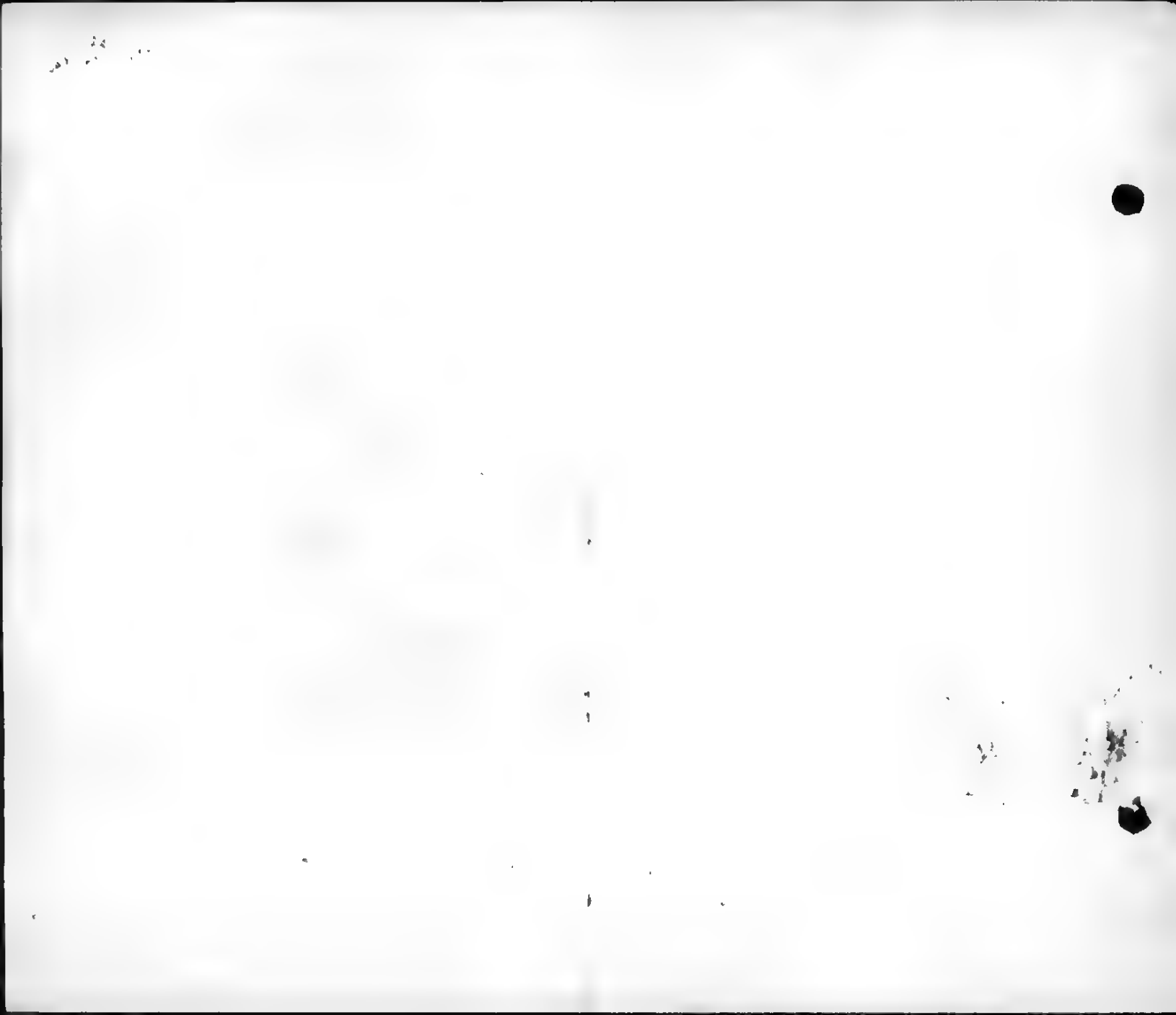
## CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	Baltimore	STATE	Maryland
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town)	Lutherville	COUNTY	Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Front and Lincoln Sts	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	Lutherville
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
Mrs. Gertrude K. Meyer		June 29th 1955	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:
female	white	married	Sept. 14, 1886
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
at home			
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Baltimore, Maryland		USA	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
Mr. Henry Slagle		Teresa Wagoner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS:			
Mr. Henry F. Meyer, Front & Lincoln			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		10 weeks	
IMMEDIATE CAUSE (A)		Carcinoma of Peritoneum	
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
14/15/55		Carcinoma of Peritoneum, inoperable	
20. AUTOPSY?			
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 5/10/55 to 6/29/55, that I last saw the deceased alive on 6/29/55, and that death occurred at 1:50 PM from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
Bennett A. Olsen		6/29/55	
M.D.		Lutherville	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. FUNERAL DIRECTOR ADDRESS	
Burial		Leonard J. Ruck, 5305 Harford Road #11	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
6-30-55		[Signature]	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND 5368

05366  
STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

Reg. Dist. No. 31

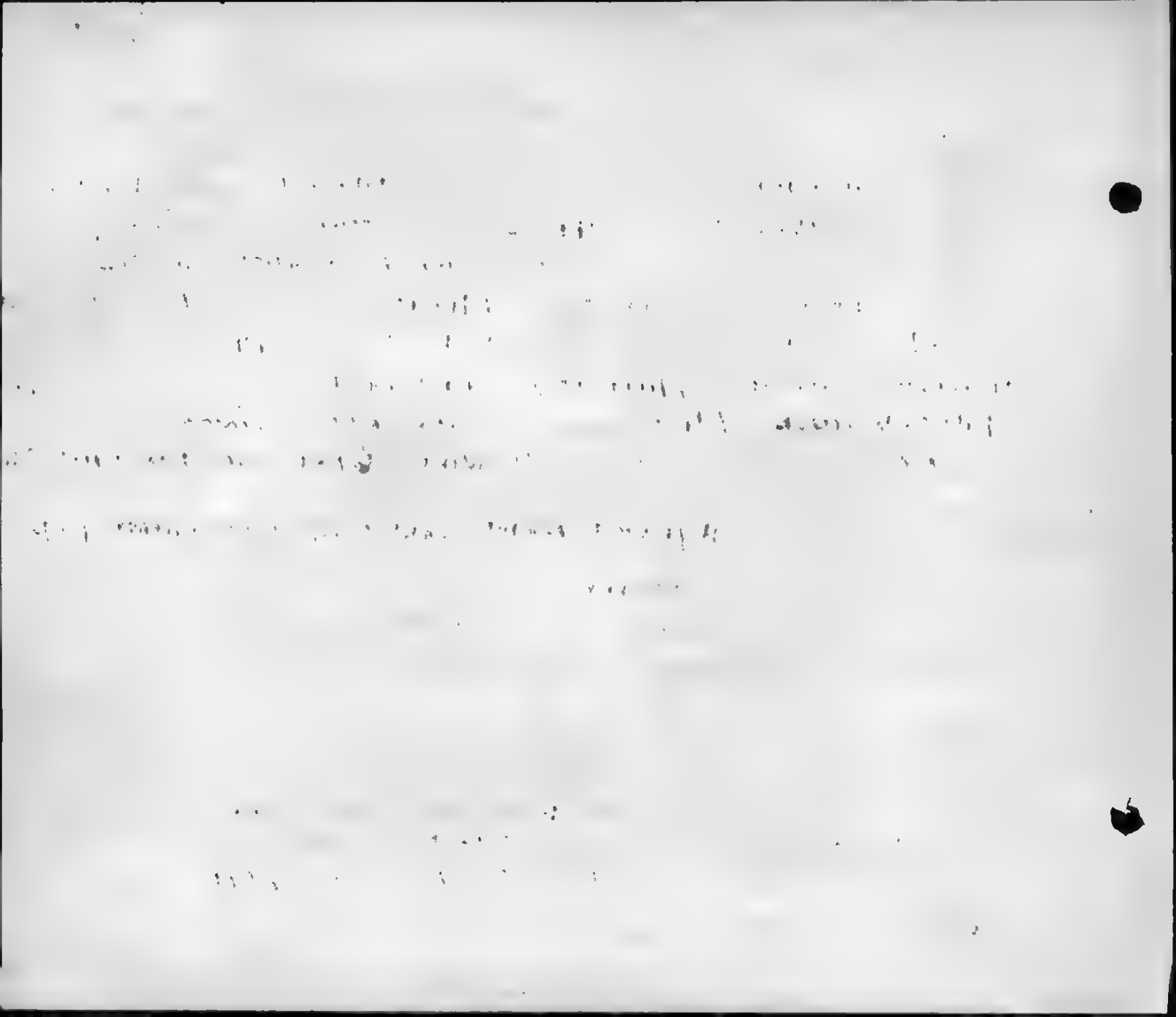
1. PLACE OF DEATH- COUNTY <b>BALTIMORE</b> CITY (If outside corporate limits, write RURAL and OR give nearest town) <b>WOODLAWN</b> HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>WOODLAWN</b>		MARYLAND LENGTH OF STAY (in this place) <b>44 yrs</b>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>MARYLAND</b> COUNTY <b>BALTO.</b> CITY (If outside corporate limits, write RURAL and give nearest town) <b>WOODLAWN (RURAL)</b> STREET ADDRESS <b>6729 WINDSOR MILL RD.</b>	
3. NAME OF DECEASED (Type or Print) <b>FRANK</b> (First) <b>GAINOR</b> (Middle) <b>MICHEL</b> (Last)		4. DATE OF DEATH <b>6</b> (Month) <b>6</b> (Day) <b>1958</b> (Year)			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <b>12-1-80</b>	9. AGE last birthday <b>74</b> yrs.	If under 1 year Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRAVELING SALESMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MILLINERY</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>THEO. GAINOR</b>		14. MOTHER'S MAIDEN NAME <b>FLORENCE GAINOR</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY No. <b>215-05-4977</b>		17. INFORMANT AND ADDRESS <b>WIFE (6729 WINDSOR MILL RD)</b>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
443X Immediate cause		(a) <b>HYPERTENSIVE CARDIO VASCULAR DISEASE</b>		1 Mo.	
Antecedent cause(s)		(b) <b>UREMIA</b>		2 DAYS	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c) <b>CARDIAC FAILURE.</b>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **DEC.**, 1958, to **JUNE**, 1955, that I last saw the deceasedalive on **6-6**, 1955, and that death occurred at **4:45 P.m.**, from the causes and on the date stated above.

SIGNATURE <b>G. P. Houck Jr.</b>		(Degree or title) <b>M.D.</b>		ADDRESS <b>RANDALLSTOWN, MD.</b>		DATE SIGNED <b>6-6-55</b>	
23. BURIAL, CREMATION REMOVAL (Specify) <b>BURIAL</b>		DATE <b>June 9, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		LOCATION (City, town, or county) <b>Woodlawn, Md.</b>	
DATE REC'D BY LOCAL REG. <b>6-8-55</b>		REGISTRAR'S SIGNATURE <b>Dr. H. H. H. H. H.</b>		24. FUNERAL DIRECTOR <b>William H. H. H.</b>		ADDRESS <b>4600 Liberty Heights Ave.</b>	

MARGIN RESERVED FOR BINDING



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12, Film 184 7-22-55 et

5369

CERTIFICATE OF DEATH

Reg. Dist. No.

05367

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Baltimore</i>	MARYLAND	STATE <i>Md</i>	COUNTY <i>Calverton</i>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Calverton</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Calverton</i>	52
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>1743 Edmondson Ave</i>	STREET ADDRESS (If rural give location) <i>1743 Edmondson Ave</i>		
3. NAME OF DECEASED: (First) (Middle) (Last) <i>CLARA - MIDDLEMAN</i>		4. DATE (Month) (Day) (Year) OF DEATH: <i>6-1-1955</i>	
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widow</i>	8. DATE OF BIRTH:
9. AGE last birthday: <i>83</i> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Housewife</i>	10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <i>Austria</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME: <i>Francis Greenfield</i>		14. MOTHER'S MAIDEN NAME: <i>Sarah</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT & ADDRESS: <i>William Middleman -</i>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
443X IMMEDIATE CAUSE (A) <i>Cerebro-Vascular Accident</i>			<i>24 hrs</i>
ANTECEDENT CAUSE (B) <i>LEFT CARDIAC FAILURE</i>			<i>6 mo.</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i>HYPERTENSIVE CARDIOVASC. DISEASE</i>			<i>10 yrs.</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Aug. 1954</i> to <i>6-1-1955</i> , that I last saw the deceased alive on <i>6-1-1955</i> , and that death occurred at <i>4:45 P.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>J. V. Houck</i>		ADDRESS <i>RANDALLSTOWN</i> DATE SIGNED <i>6-2-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>6-2-55</i>	<i>Arlington</i>	<i>Balto Md</i>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	4. FUNERAL DIRECTOR	ADDRESS
<i>6-2-55</i>	<i>G. W. Hedrick</i>	<i>Jack Lewis</i>	<i>2100 Eutan Rd</i>

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

House  
1022 Belle Ave  
Rogers

5370

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

COUNTY Towson, Ba Co.

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)  
OR  
TOWN TowsonLENGTH OF STAY  
(in this place)  
13 daysHOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS Sheppard & Enoch Pratt Hospital  
Towson 4, Maryland

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MarylandCOUNTY Balto.CITY (If outside corporate limits, write RURAL and give nearest town)  
OR  
TOWN Rural - Towson (4)STREET  
ADDRESS 225 E. Burke Avenue  
(If rural give location)3. NAME OF  
DECEASED:

(First)

(Middle)

(Last)

AlmaSatterfieldMiller4. DATE  
OF  
DEATH:

(Month)

(Day)

(Year)

6 13 1955

## 5. SEX:

6. COLOR OR  
RACE:7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)

## 8. DATE OF BIRTH:

## 9. AGE last birthday:

IF UNDER 1 YEAR IF UNDER 24 HRS.  
Months Days Hours Min.FemalewhiteMarriedAugust 23, 188668 yrs.10a. USUAL OCCUPATION Give kind of  
work done during most of working life,  
even if retired: Housewife10b. KIND OF BUSINESS OR  
INDUSTRY: OWN HOME11. BIRTHPLACE (State or foreign country):  
Richmond, Virginia12. CITIZEN OF WHAT  
COUNTRY?  
U.S.A.

## 13. FATHER'S NAME:

Joseph T. Satterfield

## 14. MOTHER'S MAIDEN NAME:

Mary Ann Seward15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates of  
service) NO NONE16. SOCIAL SECURITY No.: NONE

## 17. INFORMANT &amp; ADDRESS:

Sheppard & Enoch Pratt Hospital, Towson 4, Md.

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X  
Immediate cause(a) Cerebral hemorrhage

DUE TO

Antecedent causes (s)  
Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last.(b) Generalized arteriosclerosis

DUE TO

(c)

Interval Between  
Onset And Death1 MoUnk.

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

## 19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒21. ACCIDENT  
SUICIDE  
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,  
OF office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF INJURY m.INJURY OCCURRED  
While at Not While  
Work ☐ At Work ☐

## HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 31, 1955, to June 13, 1955, that I last saw the deceased  
alive on June 11, 1955, and that death occurred at 7:30 A.M., from the causes and on the date stated above.  
SIGNATURE (Degree or title) DATE SIGNED23. BURIAL, CREMATION,  
REMOVAL (Specify) BURIAL DATE THEREOF JUN. 15, 1955 NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL LOCATION (City, town, or county) (State) BALTIMORE, MD.DATE REC'D BY LOCAL  
REGISTRAR June 14, 1955REGISTRAR'S SIGNATURE Mabel C. Gray

24. FUNERAL DIRECTOR

ADDRESS

John Burns' Sons, Towson, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05369

5371

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Parkton P.O. - McConnel Rd.</u> LENGTH OF STAY (in this place) <u>77 years</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Parkton - McConnel Rd.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>X</u>			
3. NAME OF DECEASED: (First) <u>Cora</u> (Middle) <u>Norris</u> (Last) <u>Miller</u>				4. DATE (Month) (Day) (Year) OF DEATH. <u>June 12 1955</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>Jan. 22, 1870</u>	9. AGE last birthday <u>85</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>house</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Joshua Stockdale</u>				14. MOTHER'S MAIDEN NAME: <u>Elizabeth unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No.</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT'S ADDRESS: <u>Gilbert J. Miller, Parkton, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
18X IMMEDIATE CAUSE (A) <u>Generalized arteriosclerosis</u>						<u>years</u>	
ANTECEDENT CAUSE (B) <u>Diabetes Mellitus.</u>						<u>10 years.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>6</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 1953</u> , to <u>June 12, 1955</u> ; that I last saw the deceased alive on <u>June 10, 1955</u> , and that death occurred at <u>74</u> . M, from the causes and on the date stated above.							
SIGNATURE <u>Elizabeth B. Sherrill</u>		M.D. <u>Cockeysville, Md.</u>		DATE SIGNED <u>6/12/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>6-14-55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Carmel Methodist</u>		LOCATION (City, town, or county) (State) <u>Parkton, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6-13-55</u>		REGISTRAR'S SIGNATURE <u>Mary B. Sline</u>		24. FUNERAL DIRECTOR <u>Brooks Funeral Service, Sparks, Md.</u>		ADDRESS	

U. S. DEPARTMENT OF AGRICULTURE

JUN 17 1917

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film 184 7-25-55 et

CERTIFICATE OF DEATH

Reg. Dist. No. 053711

5372

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>md</u> COUNTY <u>Balto.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>54 Middle River</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>54 Middle River</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Home</u>				STREET ADDRESS (If rural, give location) <u>17 Cramo Lane, Trailer Ridge</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>JOSEPH E MOULD</u>				<u>JUNE 10 1955</u>			
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH: <u>4-22-1882</u>	9. AGE last birthday: <u>73 1/2</u> yrs.	10. IF UNDER 1 YEAR: Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>PA. Auditor</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>N.Y. CENTRAL</u>		11. BIRTHPLACE (State or foreign country): <u>NEW YORK STATE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>JOSEPH MOULD</u>				14. MOTHER'S MAIDEN NAME: <u>ANNA WALLACE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.):		16. SOCIAL SECURITY NO.:		17. INFORMANT & ADDRESS: <u>Clyde Mould (Son) Aborn</u>			
(If Yes, give war or dates of service)							
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
420.0 Immediate cause (a) <u>Heart Failure</u>						3 years	
Antecedent cause(s) (b) <u>arterio-sclerotic heart disease</u>						4 yrs	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:						19b. MAJOR FINDINGS OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 5, 1955</u> , to <u>June 10, 1955</u> , that I last saw the deceased alive on <u>June 3, 1955</u> , and that death occurred at <u>4:30 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Joseph Mould</u>		(DEGREE OR TITLE) <u>PA</u>		ADDRESS <u>423 Eastern Ave</u>		DATE SIGNED <u>6/10/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>June 13-55</u>		NAME OF CEMETERY OR CREMATORY: <u>Woodstock Cem.</u>		LOCATION (City, town, or county) (State): <u>Woodstock N.Y.</u>	
DATE REC'D BY LOCAL REG. <u>6/11/55</u>		REGISTRAR'S SIGNATURE: <u>Edith Hurley</u>		24. FUNERAL DIRECTOR: <u>John G. Connelly</u>		ADDRESS: <u>Essex</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

1964

1071

RECEIVED  
FBI  
JAN 14 1964

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

5373

05371

1. PLACE OF DEATH- COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Catonsville</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Catonsville</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Oakdale Ave #123</b>				STREET ADDRESS <b>123 Oakdale Ave.</b>	
3. NAME OF DECEASED (Type or Print)		(First) <b>SARAH</b>		(Middle) <b>ELLEN</b>	
		(Last) <b>MURPHY</b>		4. DATE OF DEATH <b>6-12-1955</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widow</b>	
8. DATE OF BIRTH <b>8-22-1878</b>		9. AGE last birthday <b>76</b> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Oella, Md</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Henry Sweet</b>		14. MOTHER'S MAIDEN NAME <b>Anne V. Day</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT AND ADDRESS <b>Blanche Doyle, Catonsville, Md</b>	

### 18. MEDICAL CERTIFICATION

#### 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

##### Immediate cause

##### Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a)

(b)

(c)

INTERVAL BETWEEN  
ONSET AND DEATH

#### 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION

#### 19b. MAJOR FINDINGS OF OPERATION

#### 20. AUTOPSY?

Yes ☐ No ☒

#### 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF INJURY

INJURY OCCURRED  
While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Jan 2, 1955** to **June 12, 1955**, that I last saw the deceased

alive on **June 12, 1955**, and that death occurred at **5:55** m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

#### 23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL  
REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

**F.C. Higinbotham, Ellicott City, Md**

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUNTING V. E.

JUN 15 1965

100-100000

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5374

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

05372

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Baltimore</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY <b>Baltimore</b>
CITY (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville</b>	LENGTH OF STAY (in this place) <b>6yrs</b>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Catonsville</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>207 Winters Lane</b>		STREET ADDRESS (If rural give location) <b>207 Winters Lane</b>	
3. NAME OF DECEASED: (First) (Middle) (Last) <b>HARRIETT CATHERINE NUGENT</b>		4. DATE (Month) (Day) (Year) OF DEATH: <b>June 29, 1955</b>	
5. SEX: <b>female</b>	6. COLOR OR RACE: <b>colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>widowed</b>	8. DATE OF BIRTH: <b>8-1-1867</b>
9. AGE last birthday <b>87</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>home</b>	
11. BIRTHPLACE (State or foreign country): <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME: <b>Allen Nugent</b>		14. MOTHER'S MAIDEN NAME: <b>Nancy Rheubottom</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY No. <b>none</b>	
17. INFORMANT & ADDRESS: <b>Elsie Granger, 207 Winters Lane</b>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <b>Mitral Insufficiency</b>			<b>16 Mo. 22d</b>
ANTECEDENT CAUSE (B) <b>Hypertensive Cardiac Disease</b>			<b>?</b>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>2-7-54</b> , 19...., to <b>6-29-55</b> 19...., that I last saw the deceased alive on <b>6-29-55</b> , 19...., and that death occurred at <b>1.10AM</b> , from the causes and on the date stated above.			
SIGNATURE <b>E. J. Maloney, M.D.</b>		ADDRESS <b>6-29-55</b> DATE SIGNED <b>6/29/55</b>	
M.D. <b>57 Winters Lane, Catonsville, Md.</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		DATE THEREOF <b>7-2-1955</b>	
NAME OF CEMETERY OR CREMATORY <b>White Rock</b>		LOCATION (City, town, or county) (State) <b>Carroll Co., Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR <b>JULY 21, 1956</b>		REGISTRAR'S SIGNATURE <b>C. M. Waltz</b>	
24. FUNERAL DIRECTOR ADDRESS <b>C. M. Waltz, Winfield, Maryland</b>			

IN THE COURT

OF THE STATE

OF NEW YORK

5375

## CERTIFICATE OF DEATH

Reg. Dist. No.....

## I. PLACE OF DEATH:

COUNTY Baltimore MARYLAND  
 CITY (If outside corporate limits, write RURAL OR and give nearest town) Baltimore LENGTH OF STAY (in this place)  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Home

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE md. COUNTY Balto.  
 CITY (If outside corporate limits, write RURAL and give nearest town) Essey  
 OR TOWN Essey  
 STREET ADDRESS (If rural, give location) 627 Eastern Blvd.

3. NAME OF DECEASED: (First) (Middle) (Last)  
LUCIEN F. PETERS SR.

4. DATE OF DEATH: (Month) (Day) (Year)  
June 5 1955

5. SEX: male  
 6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Apr. 12-1880

9. AGE last birth day: 75 yrs.  
 IF UNDER 1 YEAR: Months Days  
 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore

12. CITIZEN OF WHAT COUNTRY?

## 13. FATHER'S NAME:

Thomas Peters

## 14. MOTHER'S MAIDEN NAME:

Florence Mantler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.); (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

## 17. INFORMANT &amp; ADDRESS:

Mrs. Emma J. Peters (Wife) Above

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1  
 Immediate cause

(a) Coronary occlusion  
 DUE TO

Antecedent cause(s)  
 Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) Arteriosclerotic Cardio-Vascular disease 5 yrs  
 DUE TO  
 (c)

INTERVAL BETWEEN ONSET AND DEATH: Sudden

## II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

## 20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify)  
 SUICIDE  
 HOMICIDE

PLACE (Home, farm, factory, street, OF office bldg., etc.)  
 INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Not while work ☐ at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 1, 1955, to June 5, 1955, that I last saw the deceased alive on June 5, 1955, and that death occurred at 10 P.M., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

June 8-55

Parkwood

June 6 1955

Taylor Ave. Parkville Md

7-55

Dr. H. H. H. H.

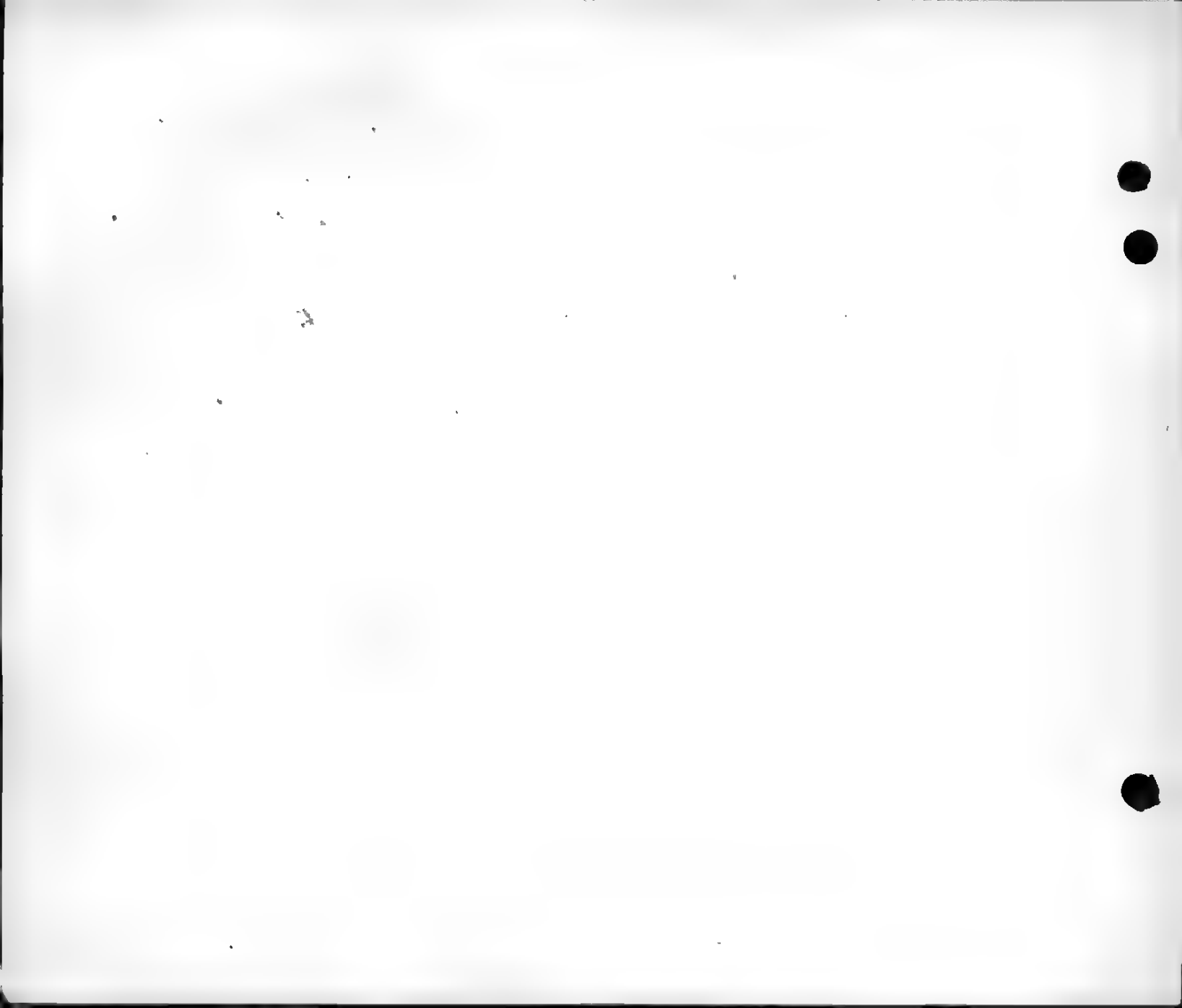
John S. Connelly

Essey

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



5376

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTO. CO.</u> MARYLAND		STATE <u>MD</u> COUNTY <u>BALTO.</u>		CITY (If outside corporate limits, write RURAL or give nearest town) OR TOWN <u>CATONSVILLE</u> 52.		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>CATONSVILLE</u> 52.	
CITY (If outside corporate limits, write RURAL or give nearest town) OR TOWN <u>CATONSVILLE</u>		LENGTH OF STAY (in this place) <u>11 1/2</u>		STREET ADDRESS (If rural give location) <u>114 LOCUST DRIVE</u>		STREET ADDRESS (If rural give location) <u>114 LOCUST DRIVE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>114 LOCUST DRIVE</u>				HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>114 LOCUST DRIVE</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>HAROLD LESLIE PHILLIPS</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>6/27/55</u> 19			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): <u>SINGLE</u>		8. DATE OF BIRTH: <u>12/6/1909</u>	
9. AGE last birthday: <u>45</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): <u>Watchman N. Harbison</u>		11. BIRTHPLACE (State or foreign country): <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>ALFORD E. PHILLIPS</u>				14. MOTHER'S MAIDEN NAME: <u>SHEPPARD</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT & ADDRESS: <u>Mrs Mildred Flohr</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						1-2 MONTHS	
IMMEDIATE CAUSE (A) <u>421X SUB-ACUTE MYOCARDITIS.</u>							
ANTECEDENT CAUSE (B) <u>DUE TO</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>DUE TO</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0 U</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>0</u> M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from ....., 19...., to ....., 19...., that I last saw the deceased alive on <u>JUNE, 15</u> , 1955., and that death occurred at <u>1:35 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		ADDRESS <u>M. D. CATONSVILLE MD</u>		DATE SIGNED <u>JUNE, 28, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>6/30/55</u>		NAME OF CEMETERY OR CREMATORY <u>MEADOWRIDGE</u>		LOCATION (City, town, or county) (State) <u>Pa.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6-30-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U.S. BUREAU OF

POSTS



5377

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u> MARYLAND	CITY <u>Baltimore</u> OR TOWN <u>Baltimore</u> MD	STATE <u>MD</u> COUNTY <u>2401-4</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> MD
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cockeysville</u>	LENGTH OF STAY (In this place) <u>3 1/2 yrs</u>	STREET ADDRESS (If rural give location) <u>426 Fresham Ave</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 Macoria Home</u>			
3. NAME OF DECEASED: (Type or Print) <u>Bettie A. O. Rumphrey</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>June 2 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Jun. 1 - 1857</u>
9. AGE last birthday: <u>98</u> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housework Own home</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Baltimore MD</u>	
11. BIRTHPLACE (State or foreign country): <u>Baltimore MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>James Owens</u>		14. MOTHER'S MAIDEN NAME: <u>Ethel Austin Kiss</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS: <u>Laura M. Schroeder</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Arterio sclerosis</u>		<u>about 3 yrs</u>	
ANTECEDENT CAUSE (B) <u>Cardio Vascular Disease</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Nov. 1952</u> to <u>June 2, 1955</u> that I last saw the deceased alive on <u>June 2, 1955</u> and that death occurred at <u>5:20 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Bettie F. Kiss</u>		DATE SIGNED <u>6/2/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY): <u>June 6/55 Greenmount Cemetery Baltimore MD</u>		24. FUNERAL DIRECTOR: <u>St Paul &amp; Creston St</u>	
DATE REC'D BY LOCAL REGISTRAR: <u>June 6, 1955</u>		REGISTRAR'S SIGNATURE: <u>L. M. Schroeder</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 6 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1805377  
5378  
CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Glen Burnie</u>			
TOWN <u>Fort Howard</u>		<u>83</u> days		STREET ADDRESS (If rural give location) <u>528 Monroe Circle</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>GEORGE E. REMLEIN</u>				OF DEATH: <u>June 26 19 55</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>1/3/17</u>	
9. AGE last birthday: <u>38</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Chauffeur</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Sebastian Remlein</u>				14. MOTHER'S MAIDEN NAME: <u>Fannie May Jordan</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes WW II</u>				16. SOCIAL SECURITY NO. <u>219-05-4876</u>			
17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>411X</u>							
ANTECEDENT CAUSE (S): <u>STENOSIS OF AORTIC VALVE AND MITRAL INSUFFICIENCY</u>						2 YEARS	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>CHRONIC RHEUMATIC ENDOCARDITIS</u>						UNKNOWN	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 4, 1955, to June 26, 1955</u> , and that death occurred at <u>5:03AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>WILLIAM B. VANDEGRIFT, M.D.</u>				ADDRESS <u>M. D. VAH, FORT HOWARD, MARYLAND</u> DATE SIGNED <u>6-27-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>JUNE 29, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		LOCATION (City, town, or county) <u>Baltimore, Maryland</u> (State)	
DATE REC'D BY LOCAL REGISTRAR <u>6/26/55</u>		REGISTRAR'S SIGNATURE <u>W. B. VandeGrift</u>		24. FUNERAL DIRECTOR <u>Wm. Cook-Bright, Inc. 6009 Harford Rd. Baltimore 14, Maryland</u>			



5379

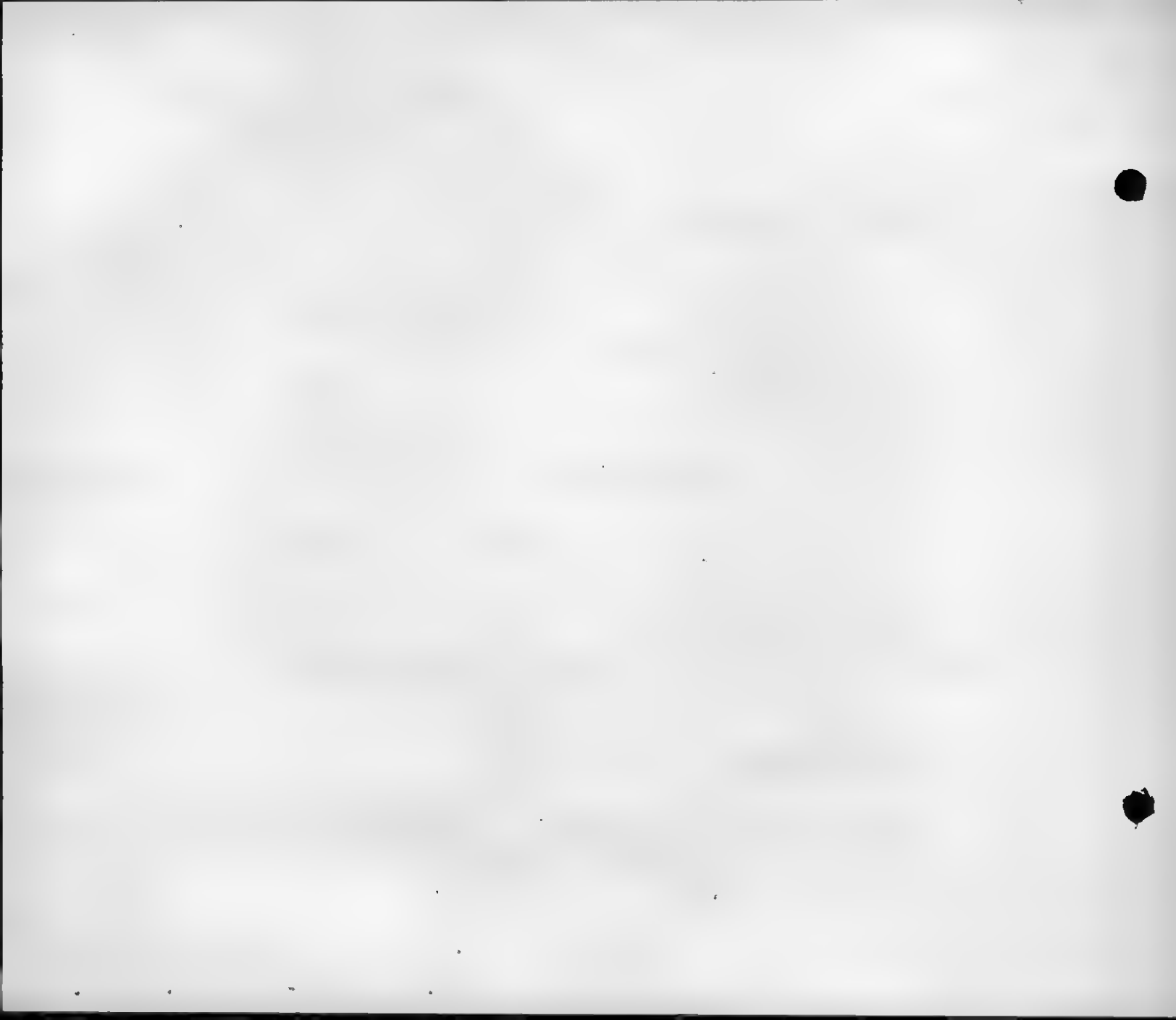
## CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Baltimore</b>	MARYLAND	STATE <b>Md.</b>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Lutherville</b>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Baltimore</b>	<b>3V 1-4</b>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>College Manor</b>		STREET ADDRESS (If rural give location) <b>3501 St. Paul St.</b>	
3. NAME OF DECEASED: (First) (Middle) (Last) <b>ROBERT P. RHODES</b>		4. DATE (Month) (Day) (Year) OF DEATH <b>June 19 19 55</b>	
5. SEX: <b>male</b>	6. COLOR OR RACE: <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>widowed</b>	8. DATE OF BIRTH: <b>May 1, 1891</b>
9. AGE last birthday: <b>64</b> yrs.		10. IF UNDER 1 YEAR: Months Days	11. IF UNDER 24 HRS.: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Ass't. Genl. Agt.</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>Insurance</b>	
11. BIRTHPLACE (State or foreign country): <b>N. C.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <b>Simon Rhodes</b>		14. MOTHER'S MAIDEN NAME: <b>Eugenia Snell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <b>no</b> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.: <b>217-03-3561</b>	
17. INFORMANT & ADDRESS: <b>Hospital Records</b>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <b>Carcinoma of pancreas</b>		<b>6 mos</b>	
ANTECEDENT CAUSE (B) <b>DUE TO</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Generalized Arteriosclerosis, severe</b>		<b>years</b>	
19A. DATE OF OPERATION: <b>0</b>	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>April 15, 1954</b> , to <b>June 19, 1955</b> , that I last saw the deceased alive on <b>June 15, 1955</b> , and that death occurred at <b>6:45 A.M.</b> from the causes and on the date stated above.			
SIGNATURE <b>J. Frank Soper, Jr.</b>		ADDRESS <b>1014 St Paul St - 2</b> DATE SIGNED <b>6/20/55</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	DATE THEREOF <b>6/21/55</b>	NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cem.</b> LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>6-21-55</b>	REGISTRAR'S SIGNATURE <b>H.W. [Signature]</b>	24. FUNERAL DIRECTOR'S ADDRESS <b>Wm. J. [Signature] &amp; Sons [Signature]</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH

05379

5276

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 41

1. PLACE OF DEATH COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7900 DUNNAN ROAD</u>		STREET ADDRESS (If rural, give location) <u>4217 SHELDON AVE</u>	
3. NAME OF DECEASED (Type or Print) <u>RUSSELL J.</u> (First) <u>J.</u> (Middle) <u>RILEY, SR.</u> (Last)		4. DATE OF DEATH <u>JUN 22</u> (Month) <u>22</u> (Day) <u>1955</u> (Year)	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>JAN 12, 1899</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES MAN</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>AUTOMOBILES</u>	9. AGE last birthday <u>56</u> yrs.	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
13. FATHER'S NAME <u>WILLIAM RILEY</u>		14. MOTHER'S MAIDEN NAME <u>LOTTIE ERHARDT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY No. <u>216-09-8410</u>	
17. INFORMANT AND ADDRESS <u>MRS. HELEN RILEY 4217 SHELDON</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) <u>Coronary Occlusion</u>		<u>10 MIN</u>
Antecedent cause(s) (b) <u>Myocarditis, Chronic</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE <u>Mrs. Mary E. Russell</u> (Degree or title)		DATE SIGNED <u>6/22/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>JUNE 22, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL</u>	LOCATION (City, town, or county) (State) <u>MD</u>
DATE REC'D BY LOCAL REG. <u>6-24-55</u>	REGISTRAR'S SIGNATURE <u>R. W. Hedrick</u>	24. FUNERAL DIRECTOR <u>ULLRICH FUNERAL HOME</u>	ADDRESS <u>4210 BELAIR</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

271

5

5380

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Baltimore</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>Baltimore</i>
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <i>X Stevenson</i>	LENGTH OF STAY (in this place) <i>28 yrs.</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>X Stevenson</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00 Valley Road</i>		STREET ADDRESS (If rural give location) <i>Valley Road</i>	

3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE OF DEATH: (Month) (Day) (Year)		
<i>WILBUR WASHINGTON RINEHEART</i>			<i>June 10 1955</i>		
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>2/22/1887</i>	9. AGE last birthday: <i>68</i> yrs.	10. IF UNDER 1 YEAR: Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Hand Gen. Farming</i>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <i>Frederick Co. Md.</i>	
13. FATHER'S NAME: <i>Jessie P. Rineheart</i>			14. MOTHER'S MAIDEN NAME: <i>Clara Brenner</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <i>No</i>			16. SOCIAL SECURITY NO.: <i>212-32-1048A</i>		
17. INFORMANT & ADDRESS: <i>Stevenson, Md.</i>			18. MEDICAL CERTIFICATION		

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
151X IMMEDIATE CAUSE (A) <i>Metastatic Ca. of liver</i>	BUE TO	<i>3 mos</i>
ANTECEDENT CAUSE (B) <i>Ca. of stomach</i>	DUE TO	<i>8 mos</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONITION CAUSING DEATH.		

19A. DATE OF OPERATION: <i>Dec. 1954</i>	19B. MAJOR FINDINGS OF OPERATION: <i>Ca. of stomach</i>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Nov. 1954*, to *June 10, 1955*, that I last saw the deceased alive on *June 10, 1955*, and that death occurred at *1:30 P.M.* from the causes and on the date stated above.

SIGNATURE *James S. Miller, Jr.* ADDRESS *Pikesville, Md.* DATE SIGNED *6/10/55*

23. BURIAL, CREMATION, REMOVAL (SPECIFY): <i>Burial</i>	DATE THEREOF: <i>6/13/55</i>	NAME OF CEMETERY OR CREMATORY: <i>Linthicum Chapel</i>	LOCATION (City, town, or county) (State): <i>Clarksville, Md.</i>
DATE REC'D BY LOCAL REGISTRAR: <i>June 14, 1955</i>	REGISTRAR'S SIGNATURE: <i>Northy R. Howell</i>	24. FUNERAL DIRECTOR: <i>Eastonsome</i>	ADDRESS: <i>Catonaville, Md.</i>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 17

FILED

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

5282

## CERTIFICATE OF DEATH

05381

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Baltimore</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5027 Ashbourne Road</u>		STREET ADDRESS (If rural, give location) <u>5027 Ashbourne Road</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Byron</u> (Middle) <u>Reynard</u> (Last) <u>Risley</u>	4. DATE OF DEATH (Month) <u>June</u> (Day) <u>20</u> (Year) <u>1955</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Mar.</u>	8. DATE OF BIRTH <u>Jan. 9, 1900</u>
9. AGE last birthday <u>55</u> yrs.		10. If under 1 year Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Refined letter carrier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>	
11. BIRTHPLACE (State or foreign country) <u>N.J.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Byron J. Risley</u>		14. MOTHER'S MAIDEN NAME <u>Johna Mary</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>216-32-3702</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Etta Risley 5027 Ashbourne Rd.</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>162X. Bronchogenic Carcinoma Left Lung</u>		<u>6 mo.</u>	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Rheumatoid arthritis</u>		<u>5 yrs.</u>	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Dec</u> , 19 <u>54</u> , to <u>June</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>June 27</u> , 19 <u>55</u> , and that death occurred at <u>1:33 A</u> .m., from the causes and on the date stated above.			
SIGNATURE <u>Dr. Bradley Laughlin M.D.</u>		ADDRESS <u>1264 Francis Ave Baltimore 27 Md</u>	
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>6-20-55</u>	NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>	LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>
DATE REC'D BY LOCAL REG. <u>6-29-55</u>	REGISTRAR'S SIGNATURE <u>AW Hedrick</u>	24. FUNERAL DIRECTOR <u>C. Howard Strong 307 W. North Ave.</u>	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

2000



5381

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

COUNTY Baltimore

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Fort Howard

MARYLAND

LENGTH OF STAY  
(In this place)40 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN BaltimoreSTREET  
ADDRESS

(If rural give location)

2409 Montebello Terrace3. NAME OF  
DECEASED:  
(Type or Print)

(First)

BENJAMIN

(Middle)

(Last)

ROBERTS

## 4. DATE (Month)

(Day)

(Year)

OF  
DEATH: June151955

## 5. SEX:

6 COLOR OR  
RACE:7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify) Married

## 8. DATE OF BIRTH:

3/15/95

## 9. AGE last birthday

IF UNDER 1 YEAR

IF UNDER 24 HRS

60 yrs.

Months

Days

Hours

Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life,  
even if retired):Janitor10B. KIND OF BUSINESS  
OR INDUSTRY:Store

## 11. BIRTHPLACE (State or foreign country):

Baltimore, Maryland12. CITIZEN OF WHAT  
COUNTRY?U.S.A.

## 13. FATHER'S NAME:

Henry Roberts

## 14. MOTHER'S MAIDEN NAME:

Hester Roberts15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates  
of service)Yes✓WW I

## 16. SOCIAL SECURITY NO.

218-09-8508

## 17. INFORMANT &amp; ADDRESS:

Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

163X

## IMMEDIATE CAUSE

(A)

CARCINOMA UPPER LOBE RIGHT LUNG;

## ANTECEDENT CAUSE (S)

~~POSSIBLE~~METASTASIS TO LEFT OCCIPITAL LOBEDISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

## 19A. DATE OF OPERATION:

## 19B. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES ☒NO ☐21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory  
OF INJURY street, office bldg., etc21C. WHERE DID (City or town)  
INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

M.

21E. INJURY OCCURRED  
While ☐ Not while ☐  
at work at work

## 21F. HOW DID INJURY OCCUR?

22. I hereby certify, that I attended the deceased from May 6, 1955, to June 15, 1955, and that death occurred at 8:10 PM, from the causes and on the date stated above.

SIGNATURE

WILLIAM B. VANDEGRIFT, M.D.

M. D.

VAH, FORT HOWARD, MD.

DATE SIGNED

6-16-5523. BURIAL, CREMATION,  
REMOVAL (SPECIFY)Burial

## DATE THEREOF

June 20, 1955

## NAME OF CEMETERY OR CREMATORY

BALTIMORE NATIONAL

## LOCATION (Ct., town, or county)

BALTIMORE, MARYLANDDATE REC'D BY LOCAL  
REGISTRAR

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

Arlington S. Phillips Funeral HomeBaltimore 17, Md.1808 N. Monroe St.

MARGIN RESERVED FOR BINDING



05383

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

5382

## CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Raspeburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Raspeburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5512 Kenwood Avenue</u>		STREET ADDRESS (If rural, give location) <u>5512 Kenwood Avenue</u>	
3. NAME OF DECEASED (First) <u>CORA M.</u> (Middle) <u>RODGERS</u> (Last)		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>29</u> (Year) <u>1955</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>Mar. 9, 1883</u>
9. AGE last birthday <u>72 yrs.</u>		10. If under 1 year: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Mins. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>waitress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Glenn L. Martin Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Rodgers</u>		14. MOTHER'S MAIDEN NAME <u>Amelia Shaney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-18-0003</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Emma Ulrich, 5512 Kenwood Ave., Balto. 6</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a).....

Sarcoma, right thigh

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause

stating the underlying cause last

(c).....

INTERVAL BETWEEN ONSET AND DEATH

1 yr.

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☐

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Not While Work ☐ At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 22, 1950, to June 29, 1955, that I last saw the deceasedalive on June 29, 1955, and that death occurred at 8:15 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)  
BURIAL

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

July 1, 1955Mr. M. D. RyfmanBelair W. Burdick, June 30, 1955  
7401 Belair Rd.

MARGIN RESERVED FOR BINNING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Dr. K. K. K.

1000

1000

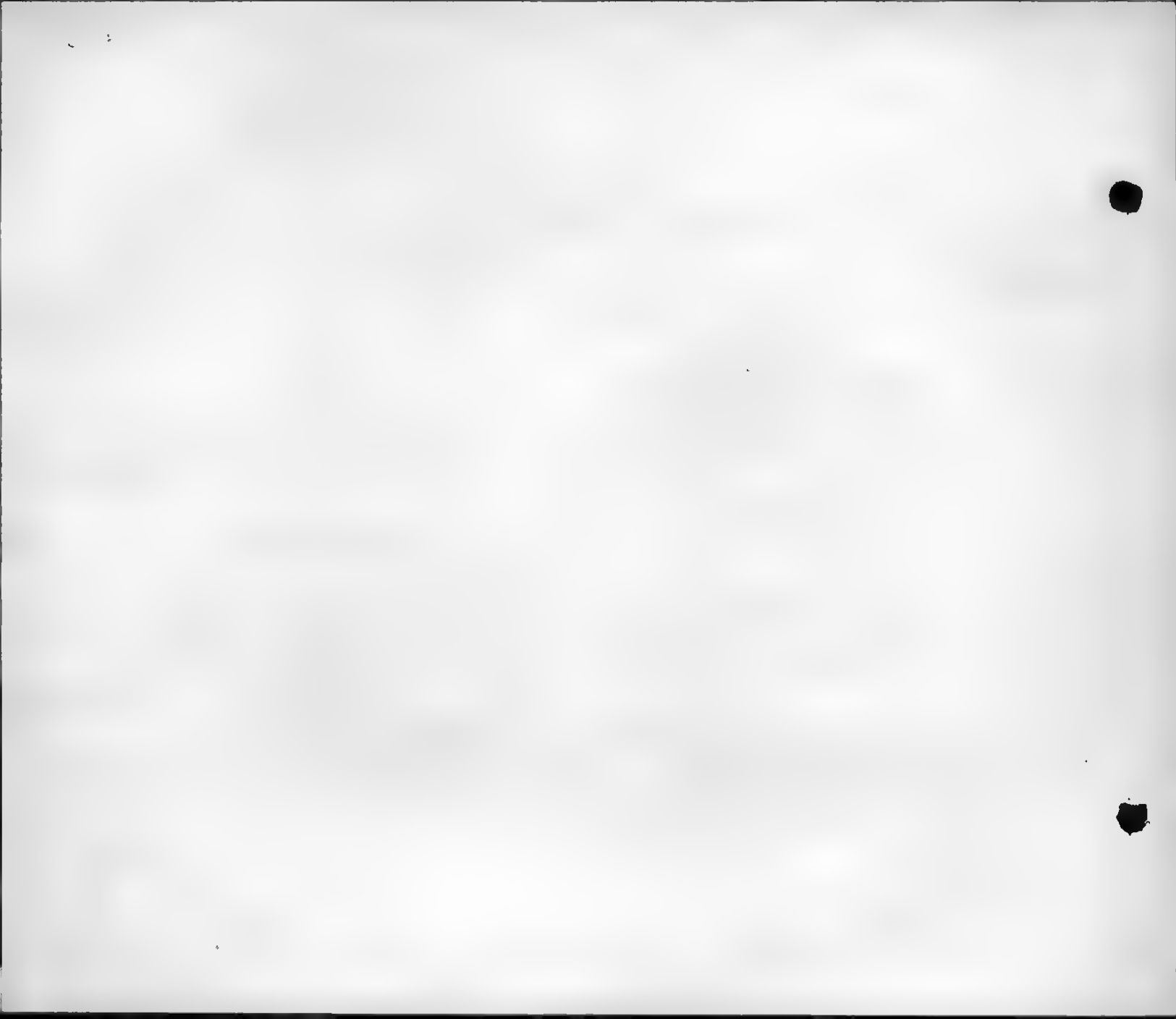
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18- 05384  
5383 CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH		2 USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Balto.</b>	MARYLAND	STATE <b>Md.</b>	COUNTY <b>1</b>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
<b>52 TOWN Catonsville</b>		<b>52 Catonsville</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<b>92 Paradise Nursing Home</b>		<b>12 S. Prospect Ave.</b>	
3. NAME OF DECEASED: (Type or Print)		4. DATE (Month) (Day) (Year)	
<b>DIANA VIOLA ROGGE</b>		<b>June 30, 19 55</b>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<b>female</b>	<b>white</b>	<b>Divorced</b>	<b>June 2, 1889</b>
9. AGE last birthday		10. BIRTHPLACE (State or foreign country):	
<b>66 yrs</b>		<b>Virginia</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life even if retired):		12. CITIZEN OF WHAT COUNTRY?	
<b>clerk - rtd</b>			
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<b>Peter Vietsch</b>		<b>Martha Paxton</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<b>no</b>			
17. INFORMANT & ADDRESS:			
<b>Mrs. Sadie Nimmo - 12 S. Prospect Ave.</b>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<b>181X</b>			
IMMEDIATE CAUSE (A)			
<b>Uremia</b>			
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
<b>Carcinoma</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<b>1 1947</b>		<b>Carcinoma bladder</b>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OR INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>6-27</b> , 19 <b>55</b> , to <b>6-30</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>6-29</b> , 19 <b>55</b> , and that death occurred at <b>1:30</b> M, from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<b>W. J. Pickens</b>		<b>7-1-55</b>	
M. D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<b>Burial</b>		<b>Loudon Park</b>	
DATE THEREOF		LOCATION (City, town, or county) (State)	
<b>7/4/55</b>		<b>Balto., Md.</b>	
DATE REC'D BY LOCAL REGISTRAR		FUNERAL DIRECTOR	
<b>7-5-55</b>		<b>Wm. J. Pickens &amp; Sons - Balto.</b>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



5384

CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u> MARYLAND		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural-Whitehall</u>		STATE <u>Md.</u> COUNTY <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural-White Hall</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ensor Rd.</u>		LENGTH OF STAY (in this place) <u>89</u>		STREET ADDRESS (If rural give location) <u>Ensor Rd.</u>			
3. NAME OF DECEASED: (First) <u>Harry</u> (Middle) <u>Rosier</u> (Last) <u>Rosier</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>June 2, 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH: <u>May 10, 1866</u>	
9. AGE last birthday <u>89</u> yrs.		10. AGE last birthday IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country): <u>White Hall Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farmer</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Farm</u>			
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Sallie Rosier</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT & ADDRESS: <u>James Almon, White Hall, Md.</u>				INTERVAL BETWEEN ONSET AND DEATH			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cardio. Vascular disease</u>							
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 15, 1953</u> , to <u>June 2, 1955</u> , that I last saw the deceased alive on <u>June 1, 1955</u> , and that death occurred at <u>6:50 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>A. M. France</u>		M. D. <u>Parkton, Md.</u>		DATE SIGNED <u>6/7/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 4, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Stablersville Cemetery</u>		LOCATION (City, town, or county) (State) <u>Parkton, Balto. Co., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6/4/55</u>		REGISTRAR'S SIGNATURE <u>Charles E. Preston</u>		FUNERAL DIRECTOR <u>Jacob Hartenstein</u>		ADDRESS <u>New Freedom, Pa.</u>	

MARGIN RESERVED FOR HINTING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7-A OUT

1977

5385

## MARYLAND STATE DEPARTMENT OF HEALTH

05386

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fullerton</u> LENGTH OF STAY (in this place) <u>4 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fullerton</u> X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>478 A. Ridge Rd</u>		STREET ADDRESS (If rural, give location) <u>478 A. Ridge Rd</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Carville</u> (Middle) <u>A.</u> (Last) <u>Royahn</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>13</u> (Year) <u>1955</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>May 31 - 1955</u> 2 weeks
9. AGE last birthday <u>14</u> If under 1 year Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>halfway</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>halfway</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Balto City md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Anthony C Royahn</u>		14. MOTHER'S MAIDEN NAME <u>Betty D Engleman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>478 A.</u>	
17. INFORMANT AND ADDRESS <u>Mr Anthony C Royahn Ridge Rd</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

754.4

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) congenital heart disease(b) probable transfusion & transfusion

(c)

INTERVAL BETWEEN ONSET AND DEATH

2 weeks

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 31<sup>st</sup>, 1955, to May 9<sup>th</sup>, 1955, that I last saw the deceased alive on May 9<sup>th</sup>, 1955, and that death occurred at 2:30a m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL CREMATION REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

## DATE REC'D BY LOCAL REG.

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

ADDRESS

June 14, 1955  
P. 552-2410

Anthony Perham  
1109 St Paul Street, Balto 2 -  
6/13/1955  
Burial  
6/14/55  
Parkwood Cem  
Balto md  
June 14, 1955  
W. M. Hedrich  
Lussan Funeral Home 7401 Balto Rd

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Paulman

1109 St Paul St.

5386

## CERTIFICATE OF DEATH

Reg. Dist. No.....

## 1. PLACE OF DEATH:

COUNTY **Baltimore**CITY (If outside corporate limits, write RURAL and give nearest town) **Baltimore**HOSPITAL OR INSTITUTION OR STREET ADDRESS **Meroy Villa - Bellona Ave.**

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **Md.** COUNTYCITY (If outside corporate limits, write RURAL and give nearest town) **Baltimore**STREET ADDRESS (If rural, give location) **106 W. University Pky.**

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

**Annie****B.****Ryan**

## 4. DATE

(Month)

(Day)

(Year)

DEATH: **June 5 19 55**

## 5. SEX:

## 6. COLOR OR RACE:

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

## 8. DATE OF BIRTH:

## 9. AGE last birthday:

IF UNDER 1 YEAR IF UNDER 24 HRS.  
Months Days Hours Min.**Female****white****single****May 16, 1871****84****yrs.**

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

## 10b. KIND OF BUSINESS OR INDUSTRY:

## 11. BIRTHPLACE (State or foreign country):

## 12. CITIZEN OF WHAT COUNTRY?

**retired****School Teacher****Baltimore, Md.**

## 13. FATHER'S NAME:

**Robert S. Ryan**

## 14. MOTHER'S MAIDEN NAME:

**Annie Boswell**

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

## 16. SOCIAL SECURITY No.:

## 17. INFORMANT &amp; ADDRESS:

**Robert B. Gould 1118 Stevenson Lane**

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

**4-20-1**  
**Immediate cause****(a) Coronary Infarction**  
**DUE TO****Antecedent cause(s)**  
**Diseases or conditions, if any, giving rise to the above cause stating underlying cause last****(b)**  
**DUE TO****(c)**

INTERVAL BETWEEN ONSET AND DEATH

**4 days**

## II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION:

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. ACCIDENT SUICIDE HOMICIDE (Specify)

## PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

## (CITY OR TOWN)

## (COUNTY)

## (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

## HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **O.C.T.**, 19**50**, to **June 5**, 19**55**, that I last saw the deceased alive on **June 3**, 19**55**, and that death occurred at **5 P.** m., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION REMOVAL (Specify):

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

## (State)

**Burial****June 7, 1955****Green Mount****Baltimore,****Md.**

## DATE REC'D BY LOCAL REG.

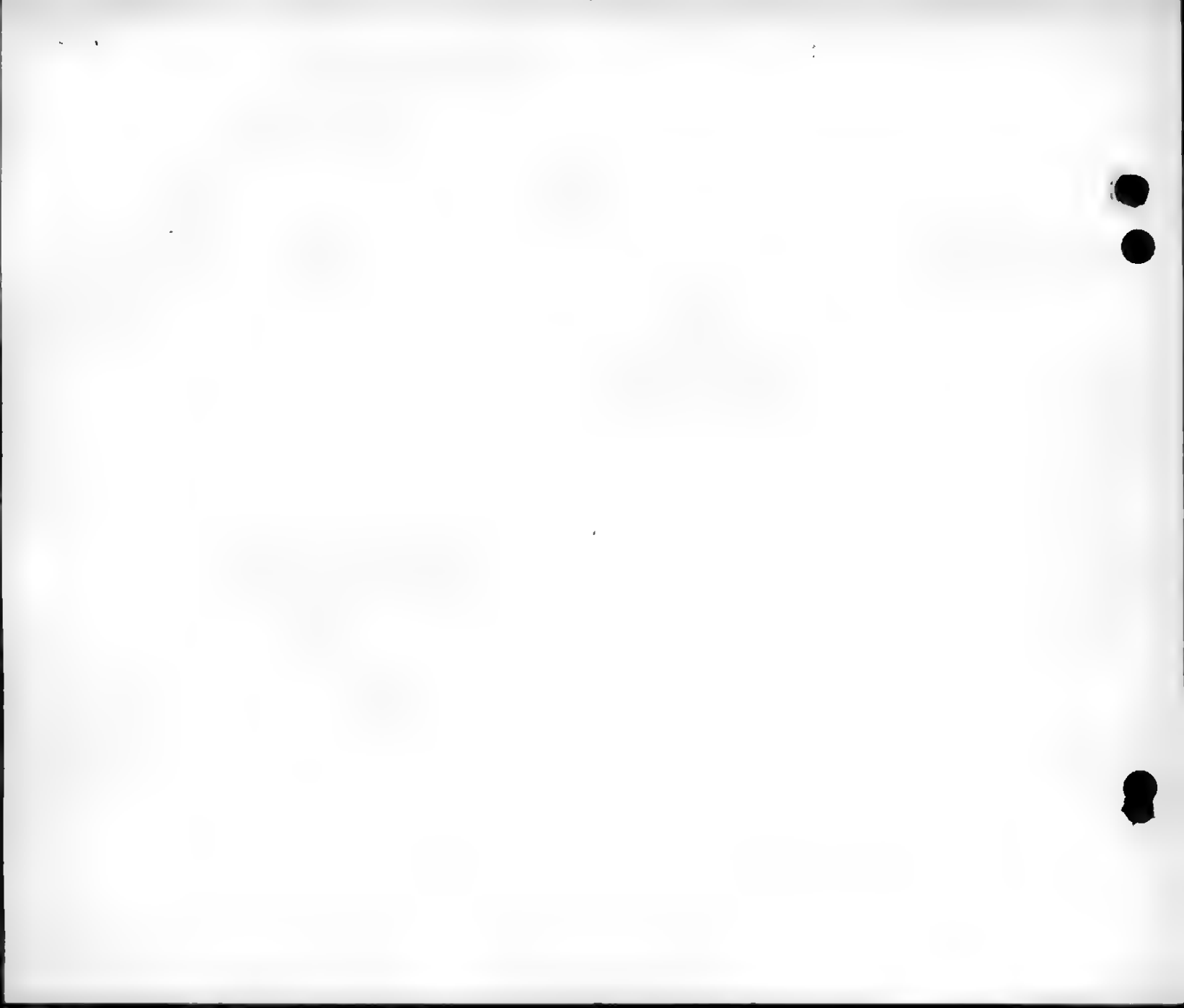
## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

## ADDRESS

**6-7-55****W. H. Hedrick****John O. Mitchell****1900 Rutaw Place**

MARGIN RESERVED FOR BINDING



**PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully! The correct age is especially important. Physicians: please write the causes of death clearly and legibly.**

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Inst. **05388**  
No. **41**

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	Baltimore	STATE	Md. COUNTY Baltimore
CITY (If outside corporate limits, write RURAL OR and give nearest town)	DUNDALK	CITY (If outside corporate limits write RURAL OR and give nearest town)	Dundalk, Md.
HOSPITAL OR INSTITUTION OR STREET ADDRESS	824 S. 50 <sup>th</sup> ST.	STREET ADDRESS	(If rural, give location) 824 S. 50 St.
3. NAME OF DECEASED:		4. DATE OF DEATH	
(Type or Print)	JOSEPH	(Month) (Day) (Year)	June 28, 1955
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
Male	White	WIDOWED	5-22-1902
9. AGE last birthday:		10. BIRTHPLACE (State or foreign country):	
53 yrs.		ITALY	
11. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		12. KIND OF BUSINESS OR INDUSTRY:	
ROLLER		STEEL MFR	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
ANGELO SACCHETTI		(UNKNOWN)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:	
3 NO		213-07-5715	
17. INFORMANT & ADDRESS:		1703 BETHLEHEM AVE DUNDALK 22, Md.	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
977X Immediate cause (a)..... Exsanguination DUE TO Antecedent cause(s) (b)..... Multiple self inflicted wounds of wrists and head Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
L			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY yard	
21c. (City or town) (County) (State)		Dundalk Baltimore Md.	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 6/28/55 M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		Cut wrists and head	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE		DATE SIGNED	
R. J. Fisher		6/29/55	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF	
BURIAL		7-1-1955	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
OAK LAWN		BALTO. Co., Md.	
DATE REC'D BY LOCAL REG.		24. FUNERAL DIRECTOR	
June 30 - 1955		William M. Kelly, 1111 North Charles St., Baltimore, Md.	

100-100000

100

100

5278

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>BALTIMORE</u> MARYLAND			STATE <u>SPRING</u> COUNTY		
CITY (If outside corporate limits, write RURAL and give nearest town) <u>53 DUNDALK 22</u>			CITY (If outside corporate limits, write RURAL and give nearest town) <u>AS SPRING 53</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>824 50TH STREET</u>			STREET ADDRESS (If rural give location) <u>#1</u>		
3. NAME OF DECEASED: (First) (Middle) (Last) <u>OLGA VIRGINIA SACCHETTI</u>			4. DATE OF DEATH: (Month) (Day) (Year) <u>6-9-1955</u>		
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH: <u>SEPT. 18, 1904</u>		
9. AGE last birthday: <u>45</u> yrs. Months Days Hours Min.			10. USUAL OCCUPATION Give kind of work done during most of working life, even if retired <u>HOUSEWIFE</u>		
11. BIRTHPLACE (State or foreign country): <u>NORTH CAROLINA</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME: <u>DOMONIC PERSICHTIN</u>			14. MOTHER'S MAIDEN NAME: <u>CELIDE ROSSI</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY No.: <u>312-22-1391</u>		
17. INFORMANT & ADDRESS: <u>JOSEPH SACCHETTI - SAME</u>					

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>521.0 CIRRHOSIS OF THE LIVER</u>		<u>12 yrs.</u>
Immediate cause (a) DUE TO		
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO		
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from <u>May 1955</u> , to <u>June 9, 1955</u> , that I last saw the deceased alive on <u>May 1955</u> , and that death occurred at <u>1 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Stephen C. Mochanah M.D.</u>		ADDRESS <u>6714 Holbrook Ave</u>	
DATE SIGNED <u>6/10/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>6-13-55</u>	<u>ST. STANISLAUS</u>	<u>BALTO. MD.</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>June 10-1955</u>	<u>William M Kelly</u>	<u>Walter P. Kelly</u>	<u>Rockville, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

05390

Reg. Dist.

No. 42

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Balto</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>51 Hialeah</u>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits write RURAL and give nearest town) <u>51 Hialeah</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4601 Rehbaum Ave</u>		STREET ADDRESS (If rural, give location) <u>4601 Rehbaum Ave</u>	
3. NAME OF DECEASED: (First) <u>Blanche</u> (Middle) <u>Cecelia</u> (Last) <u>Schaefer</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>16</u> (Year) <u>1955</u>	
5. SEX: <u>7</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>July 3 1899</u>
9. AGE last birthday: <u>62</u> yrs.		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Beauty Shop</u>	
11. BIRTHPLACE (State or foreign country): <u>Balto Md</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>John S Schaefer</u>		14. MOTHER'S MAIDEN NAME: <u>Katie C O'Neil</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>  </u>	
17. INFORMANT & ADDRESS: <u>Mrs Katherine M Schmelyer</u>			

18. MEDICAL CERTIFICATION		19. INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
<p>977X</p> <p>Immediate cause (a) <u>Self inflicted wound by cutting throat with razor blade</u></p> <p>Antecedent cause(s) (b) <u>  </u></p> <p>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Suicide</u></p>		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION: <u>  </u>	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>Leo M Kieffer</u> 1010 Reeds on		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>June 16 53</u>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAM. <input type="checkbox"/>
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>June 20 55</u>	NAME OF CEMETERY OR CREMATORY <u>Meadowdale Mem Park Elphinstone Md</u>
DATE REC'D BY LOCAL REG. <u>July 17 55</u>	REGISTRAR'S SIGNATURE <u>Leo Kieffer</u>	24. FUNERAL DIRECTOR <u>George L Schuch</u> ADDRESS <u>Federick Ave</u>

MARGIN RESERVED FOR BINDING

VS. A15A-5-53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S. A. STONE

U.S.

Copyright

MARYLAND 5387

STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY		Baltimore		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE		Maryland		COUNTY		Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWNSHIP		Towson		CITY (If outside corporate limits, write RURAL and give nearest town) TOWNSHIP		Towson		STREET ADDRESS		(If rural, give location) 6700 Canongate Road	
3. NAME OF DECEASED (Type or Print)		Mr. George Henri Schmidt		4. DATE OF DEATH		June 5th		1955			
5. SEX		male		6. COLOR OR RACE		white		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		married	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Teacher		8. DATE OF BIRTH		Aug. 6, 1895		9. AGE last birthday		60 yrs.	
11. BIRTHPLACE (State or foreign country)		Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?		USA		13. FATHER'S NAME		Mr. George J. Schmidt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		Yes		16. SOCIAL SECURITY NO.		217-18-6647		17. INFORMANT AND ADDRESS		Mrs. Mildred R. Schmidt, 6700 Canongate Rd.	
18. MEDICAL CERTIFICATION		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH		2 years		19. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		21. ACCIDENT SUICIDE HOMICIDE		(Specify)	
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY)		(STATE)			
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED		HOW DID INJURY OCCUR?							
OF INJURY		While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>									
22. I hereby certify that I attended the deceased from		21 Apr. 1954 to 5 June 1955, that I last saw the deceased		23. BURIAL, CREMATION REMOVAL (Specify)		Burial		DATE		June 8, 1955	
alive on		4 June 1955, and that death occurred at		NAME OF CEMETERY OR CREMATORY		Loudon Park Cemetery		LOCATION (City, town, or county)		Baltimore, Maryland	
SIGNATURE		(Degree or title)		ADDRESS		1207 Eutanil Baltimore MD		DATE SIGNED		6 June 55	
DATE REC'D BY LOCAL REG.		6/6/55		24. FUNERAL DIRECTOR		Leonard J. Ruck, 5305 Harford Road #14					

MARGIN RESERVED FOR BINDING

Dr. Hamberger  
1207 Eutaw Place  
LA 3 9802  
MA 3 0178

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Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 2771-4

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>2771-4</u>
CITY (If outside corporate limits, write RURAL) OR TOWN <u>Baltimore Balto 6, 1st</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Baltimore 2 4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4225 Darleigh Rd.</u>		STREET ADDRESS (If rural, give location) <u>121 N. Ellwood ave</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>Anna</u>	(Middle) <u>M. J.</u>	(Last) <u>Schneider</u>	(Month) <u>June</u> (Day) <u>11</u> (Year) <u>1955</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>June 6/1891</u>
9. AGE last birthday: <u>64</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>None</u>		12. CITIZEN OF WHAT COUNTRY? <u>Balto. md.</u>	
13. FATHER'S NAME: <u>Fredrick Borkman</u>		14. MOTHER'S MAIDEN NAME: <u>Elizabeth ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u></u>	
17. INFORMANT'S ADDRESS: <u></u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause (a) <u>Coronary occlusion</u>		<u>12 hours</u>
Antecedent cause(s) (b) <u>Card. Veg. Heart Disease</u>		
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>years</u>		
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town)	(County)	(State)
21d. TIME (Month) (Day) (Year) (Hour) OF <u>dark June 11 55 7:30</u> M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?		

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

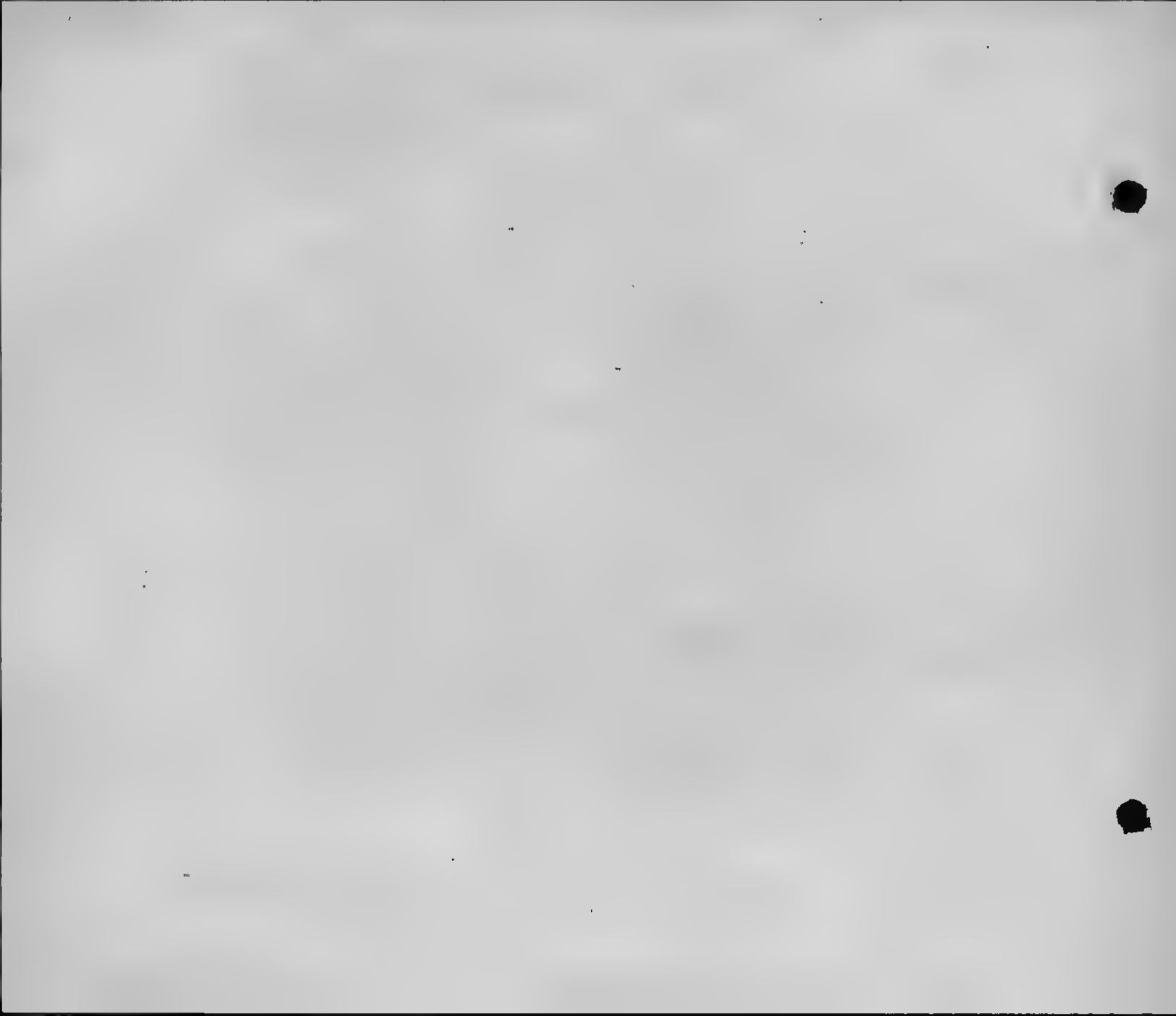
SIGNATURE Ambarine M.D. M. D. CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify): <u>Interred</u>	DATE THEREOF: <u>6/15/55</u>	NAME OF CEMETERY OR CREMATORY: <u>Green Haven Memorial Park</u>	LOCATION (City, town, or county) (State): <u>Maryland</u>
DATE REC'D BY LOCAL REG. <u>7-13-55</u>	REGISTRAR'S SIGNATURE: <u></u>	24. FUNERAL DIRECTOR: <u>James P. H. B. L.</u>	ADDRESS: <u>3000 E. Balto St.</u>

MARGIN RESERVED FOR BUNDLING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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Item 18 File # 826-22-55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

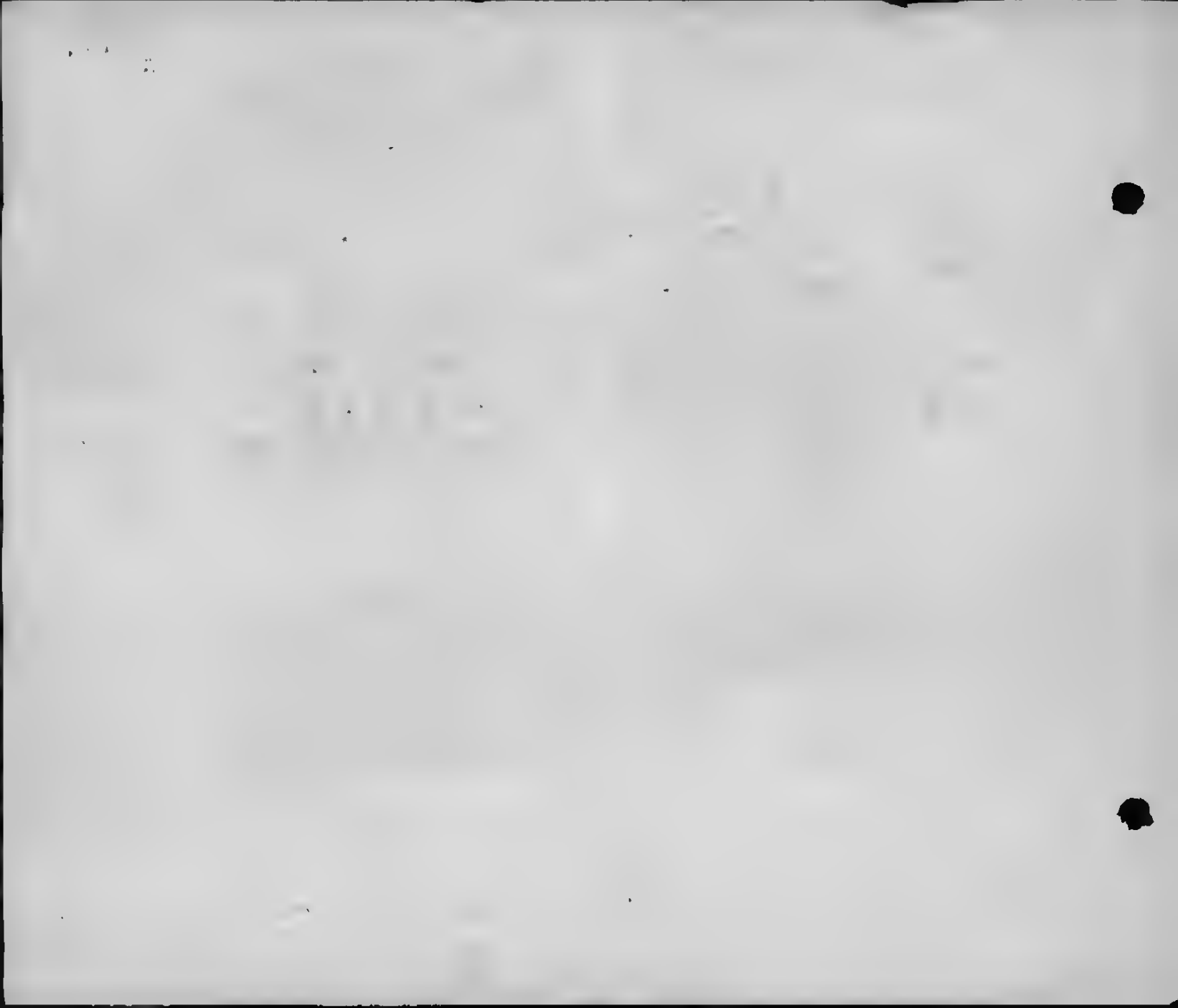
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Baltimore</b>		MARYLAND		STATE <b>Md.</b>		COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL OR, and give nearest town) <b>ROCKFORDS-Point</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) <b>Baltimore 22</b>			
HOSPITAL OR INSTITUTION <b>BETHLEHEM-STEEL INFIRMARY</b>				STREET ADDRESS (If rural, give location) <b>7611 S. Bend Road</b>			
3. NAME OF DECEASED: (First) (Middle) (Last) <b>KARL B. SCHULTZ</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>6 6 19 55</b>			
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Married</b>	8. DATE OF BIRTH: <b>Aug 11, 1925</b>	9. AGE last birthday: (If under 1 year) (If under 24 hrs.) <b>29 yrs.</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of work life, or if (retiree)) <b>TAXI DRIVER</b>		10b. KIND OF BUSINESS OR INDUSTRY: <b>OIL-BUSINESS</b>		11. BIRTHPLACE (State or foreign country): <b>BALTO, MD.</b>		12. CITIZEN OF WHAT COUNTRY: <b>U.S.A.</b>	
13. FATHER'S NAME: <b>KARL SCHULTZ</b>				14. MOTHER'S MAIDEN NAME: <b>GERCZAK</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <b>RUTH SCHULTZ (SAME)</b>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
Immediate cause (a)..... <b>Arteriosclerotic cardiovascular disease</b>		DUE TO			
Antecedent cause(s) (b)..... Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		DUE TO			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <b>Ruth Schult</b>		M. D.		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (Specify): <b>Burial</b>		DATE THEREOF <b>June 10, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>BALTO-NATIONAL</b>	
DATE REC'D BY LOCAL REG. <b>6-7-55</b>		REGISTRAR'S SIGNATURE <b>Dr. W. Sedgwick</b>		24. FUNERAL DIRECTOR <b>John G. Connelly, Esq., Md.</b>	

MARGIN RESERVED FOR BINDING

VS A15A-5-53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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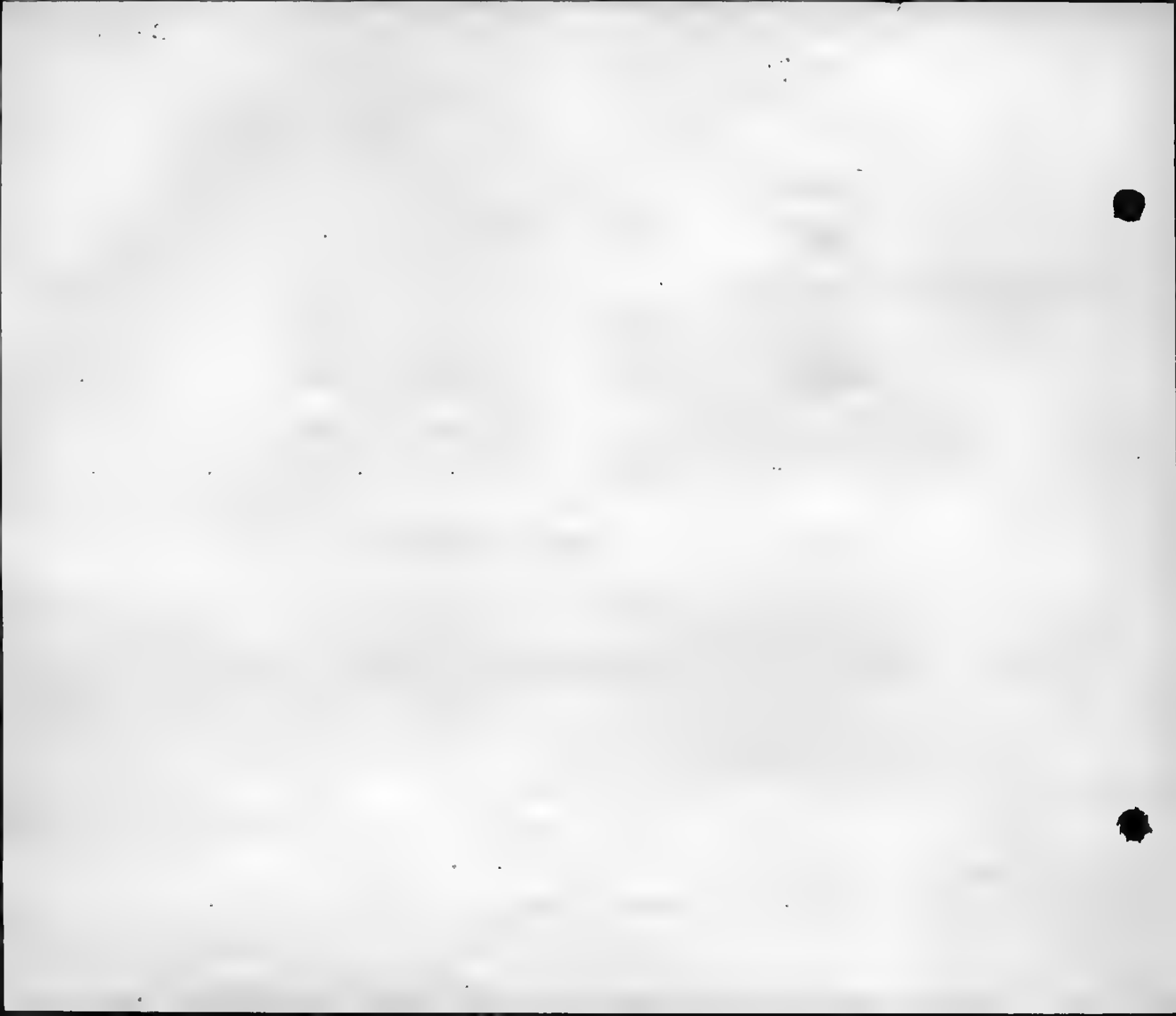
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>BALTIMORE</b>		MARYLAND		STATE <b>MARYLAND</b>		COUNTY	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>FORT HOWARD</b>		<b>7 DAYS</b>		TOWN <b>BALTIMORE</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>VETERANS ADMINISTRATION HOSPITAL</b>				STREET ADDRESS (If rural give location) <b>312 W. CAMDEN STREET</b>			
3. NAME OF DECEASED: (Type or Print) <b>CHARLES E. SCULLEY</b>				4. DATE (Month) (Day) (Year) OF DEATH: <b>JUNE 9 1955</b>			
5. SEX: <b>MALE</b>		6. COLOR OR RACE: <b>WHITE</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <b>DIVORCED</b>		8. DATE OF BIRTH: <b>9/26/88</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>LABORER</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>SHIP YARD</b>		9. AGE last birthday: <b>66 yrs</b>		11. BIRTHPLACE (State or foreign country): <b>CENTREVILLE, MARYLAND</b>	
13. FATHER'S NAME: <b>JOHN SCULLEY</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>YES WW-I</b>				14. MOTHER'S MAIDEN NAME: <b>ELIZABETH NICKERSON</b>			
16. SOCIAL SECURITY NO. <b>UNKNOWN</b>				17. INFORMANT & ADDRESS: <b>CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MD.</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						UNKNOWN	
IMMEDIATE CAUSE (A) <b>CEREBRAL THROMBOSIS</b>							
ANTECEDENT CAUSE (S): (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>							
19A. DATE OF OPERATION: <b>0</b>						19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>June 2, 1955</b> , to <b>June 9, 1955</b> , and that death occurred at <b>7:00 P.M.</b> , from the causes and on the date stated above.							
SIGNATURE <b>Francis G. Dickey</b>				ADDRESS <b>VAH, FORT HOWARD, MD.</b>		DATE SIGNED <b>6/10/55</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		DATE THEREOF <b>JUNE 14, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
DATE REC'D BY LOCAL REGISTRAR <b>6-13-55</b>		REGISTRAR'S SIGNATURE <b>Wm. Cook</b>		24. FUNERAL DIRECTOR ADDRESS <b>WM. COOK - BLIGHT FUNERAL HOME 6009 Harford Rd. Baltimore, Md.</b>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND

5391

05395

STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u> X	
TOWN <u>Reisterstown</u>		TOWN <u>Reisterstown</u>	
HOSPITAL OR INSTITUTION, OR STREET ADDRESS <u>42 Westminister Road</u>		STREET ADDRESS (If rural, give location) <u>42 Westminister Road</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>ARTHUR EVERETT SHAMBERGER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 7 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 16, 1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John A. Chamberger</u>		14. MOTHER'S MAIDEN NAME <u>Louise A. Chamberger</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>1-1-1-1-1-1-1-1-1-1</u>	
17. INFORMANT AND ADDRESS <u>Mr. &amp; Mrs. E. Chamberger, Reisterstown, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
434.1 Immediate cause (a).....		Interval Between Onset and Death <u>24 hours</u>	
Antecedent cause(s) (b).....		<u>24 hours</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c).....			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 7/1955</u> , to <u>June 8, 1955</u> , that I last saw the deceased alive on <u>June 7, 1955</u> , and that death occurred at <u>2:00 A.M.</u> from the causes and on the date stated above.			
SIGNATURE (Degree or title) <u>Caroline E. Chamberger, M.D.</u>		ADDRESS <u>Reisterstown, Md.</u>	
DATE SIGNED <u>June 8, 1955</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>June 11/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>	
DATE REC'D BY LOCAL REG. <u>6-10-55</u>		24. FUNERAL DIRECTOR <u>J.F. Eline &amp; Sons, Reisterstown, Md.</u>	
REGISTRAR'S SIGNATURE <u>Mary B. Zline</u>		ADDRESS <u>J.F. Eline &amp; Sons, Reisterstown, Md.</u>	

MARGIN RESERVED FOR BINDING

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## CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Baltimore</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Baltimore</i>	
CITY (If outside corporate limits, write OR and give nearest town) <i>Ridewood</i>		RURAL LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write OR and give nearest town) <i>Ridewood</i>		RURAL and give nearest town) <i>X</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Roldrew Ave.</i>				STREET ADDRESS (If rural give location) <i>Roldrew Ave.</i>			
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE OF DEATH: (Month) (Day) (Year)				
<i>MAMIE VIRGINIA SHARRER</i>			<i>June 12, 1955</i>				
5. SEX: <i>F.</i>	6. COLOR OR RACE: <i>W.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>Aug. 21, 1880</i>	9. AGE last birthday: <i>74</i> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY: <i>Own home</i>	11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME: <i>George L. Roller</i>				14. MOTHER'S MAIDEN NAME: <i>Sydney Ann Roller (?)</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY No.: <i>None</i>		17. INFORMANT & ADDRESS: <i>Family Records</i>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				Interval Between Onset And Death			
<i>420.0</i>				<i>same</i>			
Immediate cause				<i>3 weeks</i>			
(a) <i>congestive heart failure, chronic</i>				<i>more than 10 years</i>			
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.				<i>more than 10 years</i>			
(b) <i>arteriosclerotic heart disease</i>							
(c) <i>generalized arteriosclerosis</i>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Diabetes mellitus</i>							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Feb. 4, 1955</i> , to <i>June 12, 1955</i> , that I last saw the deceased alive on <i>June 12, 1955</i> , and that death occurred at <i>6:20 PM</i> , from the causes and on the date stated above.							
SIGNATURE <i>Gene R. Towder</i>				DATE SIGNED <i>June 15, 1955</i>			
(Degree or title) <i>M.D.</i>				ADDRESS <i>Lutherville, Md.</i>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>June 15, 1955</i>		<i>Arnold Ridge Cem.</i>		<i>Pikesville, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>June 14, 1955</i>		<i>Mabel C. Gray</i>		<i>John Burke Bone, Towson, Md.</i>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

E. A. ANTHONY

Subl. 24. 1965

11/17

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the uses of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH: COUNTY <u>Baltimore Co</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>	
TOWN <u>PARKVILLE</u>		TOWN <u>PARKVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8008 HARFORD RD</u>		STREET ADDRESS (If rural, give location) <u>8008 HARFORD RD</u>	
3. NAME OF DECEASED (Type or Print) <u>MARY MARET</u> (First) <u>SHAW</u> (Middle) <u>SHAW</u> (Last)		4. DATE OF DEATH <u>JUNE 27</u> (Month) <u>27</u> (Day) <u>1955</u> (Year)	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>NOV 3 1892</u>
9. AGE last birthday <u>62</u> yrs.		10. If under 1 year Months Days Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>THEODORE HEISNER</u>		14. MOTHER'S MAIDEN NAME <u>REBECCA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>MRS FRANK P HEISNER 417 Royal Lane</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
420.0 Immediate cause (a) <u>myocardial infarction</u>			<u>10 hrs</u>
Antecedent cause(s) (b) <u>coronary artery disease</u>			<u>5 years</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Hypertensive atherosclerotic heart disease</u>			<u>3 years</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 26, 1955</u> to <u>June 27, 1955</u> ; that I last saw the deceased alive on <u>June 27, 1955</u> , and that death occurred at <u>1:30</u> p.m., from the causes and on the date stated above.			
SIGNATURE <u>Robert M. Mager MD</u>		ADDRESS <u>5716 Beechdale Ave</u> DATE SIGNED <u>June 27, 1955</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>6/30/55</u>	
NAME OF CEMETERY OR CREMATORY <u>LODGE PARK</u>		LOCATION (City, town, or county) (State) <u>Balto MD</u>	
DATE REC'D BY LOCAL REG. <u>6/28/55</u>		REGISTRAR'S SIGNATURE <u>U.M. Bacon</u>	
24. FUNERAL DIRECTOR <u>Charles H. Grawshaw</u>		ADDRESS <u>8802 HARFORD RD</u>	

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CERTIFICATE OF DEATH

Reg. Dist. No. ... 30

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u> MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Ellicott City</u>	STATE <u>Md.</u> COUNTY <u>Baltimore</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Ellicott City</u>
X TOWN <u>Rural Ellicott City</u>	LENGTH OF STAY (in this place) <u>87 yrs</u>	STREET ADDRESS (If rural give location) <u>River Road</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>River Road</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
<u>MARY ANN SHECKELLS</u>		<u>June 22 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>7-24-1867</u>
		9. AGE last birthday: <u>87</u> yrs	10. UNDER 1 YEAR: Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife Own Home</u>	10B. KIND OF BUSINESS OR INDUSTRY: <u>Maryland</u>	11. BIRTHPLACE (State or foreign country): <u>Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME: <u>Nicholas Laumann</u>	14. MOTHER'S MAIDEN NAME: <u>Susan A. Johnson</u>		
15. WAS DECEASED EVER IN U.S. ARMY OR NAVY (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No.</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT & ADDRESS: <u>Miss Sue A. Laumann, Ellicott City, Md.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>CHRONIC MYOCARDITIS (NEUROVASCULAR)</u>			<u>10 yrs</u>
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>00</u>	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>0</u>	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <u>Eastonville</u>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>0</u> M.	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from ... 1948 to 6/22/55, 1955 that I last saw the deceased alive on 6/14/55, and that death occurred at 1:10 P.M. from the causes and on the date stated above.			
SIGNATURE <u>J. Lloyd Johnson</u> M.D.		DATE SIGNED <u>6/23/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>6-25-55</u>	NAME OF CEMETERY OR CREMATORY <u>London Park</u>	LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
DATE REC'D BY LOCAL REGISTRAR <u>6-24-55</u>	REGISTRAR'S SIGNATURE <u>B W Laumann</u>	24. FUNERAL DIRECTOR ADDRESS <u>Eastonville, Eastonville, Md.</u>	

MARGIN RESERVED FOR BINDING

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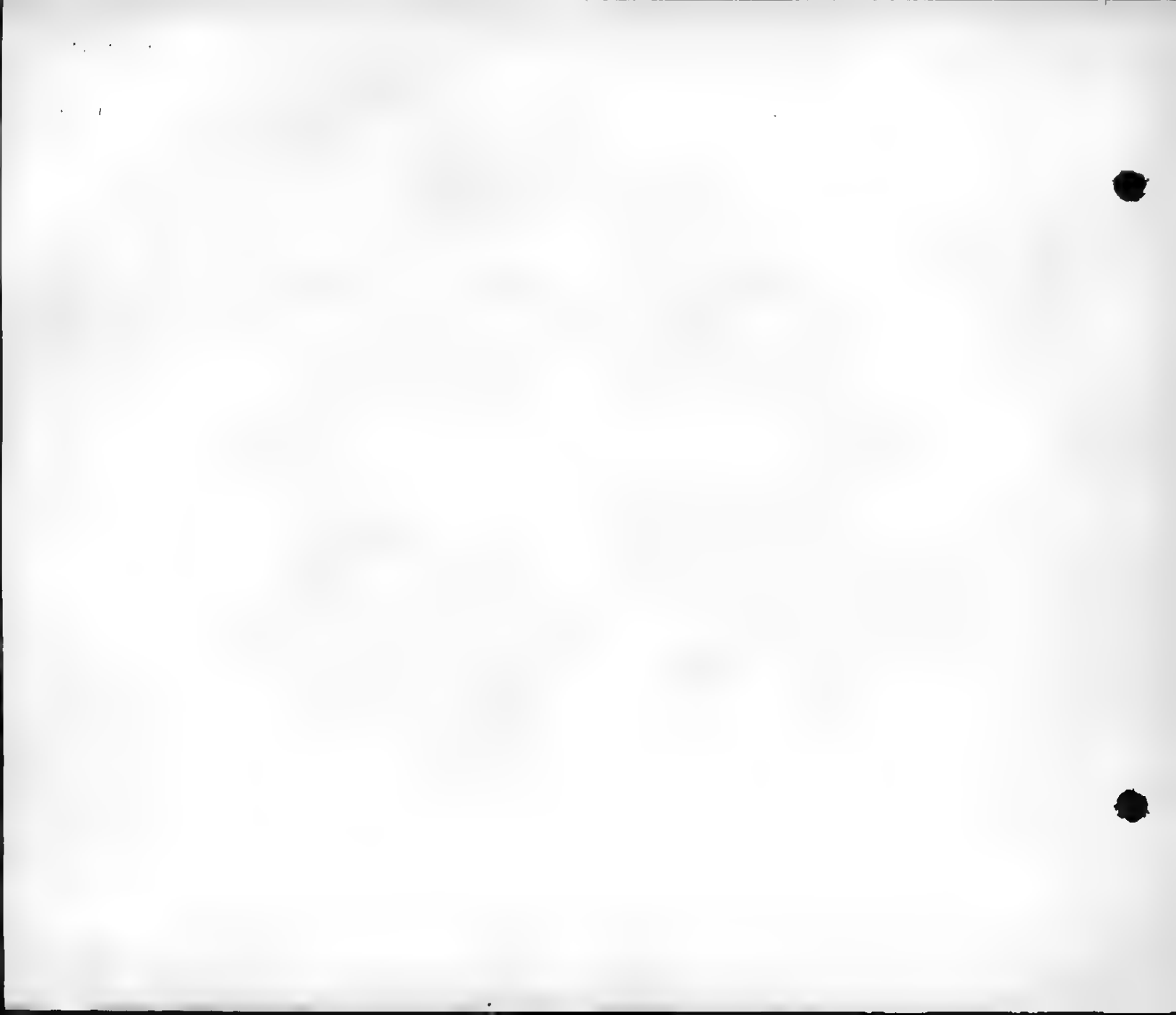
## CERTIFICATE OF DEATH

Reg. Dist. No. 62

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTIMORE</u>	MARYLAND	STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
51 TOWN <u>HALETHORPE</u>	25 YRS.	51 TOWN <u>HALETHORPE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
100 <u>1815 MAYFIELD AVE</u>		<u>1815 MAYFIELD AVE</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) (Middle) (Last)		OF DEATH: <u>JUNE 25 1955</u>	
5. SEX: 6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
MALE WHITE	MARRIED	SEPT. 7, 1974	80 yrs
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):
PRINTER		SUN PAPER	MARYLAND
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
HANS NICKOLAS SIEVERT		GERTRUDE DROTHER.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
4		213-03-2417	
17. INFORMANT & ADDRESS:			
MARY SIEVERT 1815 MAYFIELD AVE.			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
334X IMMEDIATE CAUSE			
(A) DUE TO Cerebral arterio Sclerosis - E dementia			5 years
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
4B) Inability to Swallow -			
(C) DUE TO dehydration			3 or 4 days
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from _____, 1953, to June 1, 1955, that I last saw the deceased alive on June 24, 1955, and that death occurred at _____ M, from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
Frederick V. Decker		M.D. 1911 Francis George Belton - Md.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
BURIAL		JUNE 28, 1955	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
LONDON PARK		BALTIMORE, MARYLAND	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR ADDRESS	
6-27-55		Joseph J. Ambrose, 13250 Delphian Sp. Rd.	

MARGIN RESERVED FOR BINNING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



5395

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Parkville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Parkville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>9646 Dixon Avenue</u>				STREET ADDRESS (If rural give location) <u>9646 Dixon Avenue</u>			
3. NAME OF DECEASED: (First) <u>Mr. Joseph</u> (Middle) <u>Charles</u> (Last) <u>Simpson Sr</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>June 13th</u> 19 <u>55</u>			
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>Jan. 14, 1893</u>	9. AGE last birthday <u>62</u> yrs.	10. UNDER 1 YEAR Months	11. UNDER 24 MRS. Days	12. UNDER 36 HRS. Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Carpenter</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Harford Co. Maryland</u>	
13. FATHER'S NAME: <u>Richard Simpson</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>215-07-3134</u>		17. INFORMANT & ADDRESS: <u>Mrs. Margaret M. Simpson, 9646 Dixon Ave.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Acute coronary occlusion</u>						<u>24 hours</u>	
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>260x</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes mellitus</u>						<u>Many years</u>	
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 1, 1955</u> , to <u>June 13, 1955</u> , that I last saw the deceased alive on <u>June 12, 1955</u> , and that death occurred at <u>1:30 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Helmut Knebel</u>		ADDRESS <u>800 Harford Rd.</u>		DATE SIGNED <u>June 14, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 16, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6-15-55</u>		REGISTRAR'S SIGNATURE <u>Helmut Knebel</u>		24. FUNERAL DIRECTOR <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Road #14</u>	

MARGIN RESERVED FOR BINDING

VS. A15-10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Harris  
8100 Harford Road

5396

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	Baltimore	STATE	Maryland
CITY (If outside corporate limits, write RURAL and give nearest town)	Port Howard	COUNTY	12-11
TOWN	Port Howard	CITY (If outside corporate limits, write RURAL and give nearest town)	Baltimore, 22
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Veterans Administration Hospital	STREET ADDRESS (If rural give location)	7531 Westfield Road
3. NAME OF DECEASED: (Type or Print)	(First) THOMAS (Middle) (NMI) (Last) SMITH	4. DATE OF DEATH: (Month) (Day) (Year)	June 19 19 55
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Divorced	8. DATE OF BIRTH: 10/27/72
9. AGE last birthday, IF UNDER 1 YEAR Months Days		9. AGE last birthday, IF UNDER 24 HRS Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Freight Clerk		10B. KIND OF BUSINESS OR INDUSTRY: Railroad	
11. BIRTHPLACE (State or foreign country): Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Edward		14. MOTHER'S MAIDEN NAME: Ellen MN: Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT & ADDRESS: Clin. Rec. Vet. Adm. Hosp, Ft. Howard, Md.			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Unknown	
IMMEDIATE CAUSE (A) Carcinoma Of the Prostate with Generalized Metastasis			
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
22. I hereby certify that I attended the deceased from June 17, 1955, to June 19, 1955 and that death occurred at M. from the causes and on the date stated above.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
Burial		JUNE 23, 1955	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Baltimore National		Baltimore, Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
6-21-55		R. A. Hedrick	
24. FUNERAL DIRECTOR		ADDRESS	
Wm. Cook-Blight Funeral Home		6009 Harford Rd. Baltimore, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



05402

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 16, Film 6184 7-14-55 et

5397

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>BALTIMORE</b>		MARYLAND		STATE <b>MARYLAND</b>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		LENGTH OF STAY (in this place) <b>13 HOURS</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>VETERANS ADMINISTRATION HOSPITAL</b>				STREET ADDRESS (If rural give location) <b>436 NORTH PULASKI STREET</b>			
3. NAME OF DECEASED: (First) <b>OLIVER</b> (Middle) <b>SMULLEN</b> (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <b>JUNE 21 19 55</b>			
5. SEX: <b>MALE</b>		6. COLOR OR RACE: <b>WHITE</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED: <b>MARRIED</b>		8. DATE OF BIRTH: <b>11-18-93</b>	
9. AGE last birthday: <b>61</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>LATHER</b>		11. BIRTHPLACE (State or foreign country): <b>WICOMICO COUNTY, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME: <b>FRANK SMULLEN</b>				14. MOTHER'S MAIDEN NAME: <b>ELLENORA RICHARDSON</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <b>YES</b> (If Yes, give war or dates of service): <b>WW I</b>				16. SOCIAL SECURITY NO.: <b>213-12-8511</b>			
17. INFORMANT & ADDRESS: <b>CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MD.</b>							
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<b>420.0</b>							
IMMEDIATE CAUSE (A) <b>MYOCARDIAL INFARCTION</b>				<b>1 DAY</b>			
ANTECEDENT CAUSE (S) <b>ARTERIOSCLEROTIC CORONARY THROMBOSIS</b>				<b>1 DAY</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST <b>ARTERIOSCLEROTIC HEART DISEASE</b>				<b>UNKNOWN</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <b>0</b>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>11:30 AM. 12:30 AM</b>			
22. I hereby certify that I attended the deceased from <b>JUNE 20, 19 55</b> , to <b>JUNE 21, 19 55</b> and that death occurred at <b>12:30 M.</b> from the causes and on the date stated above.							
SIGNATURE <b>Irving Freeman</b> Acting <b>IRVING FREEMAN, M.D., Chief, Medical Service</b>				ADDRESS <b>M. D. VAH, FORT HOWARD, MARYLAND</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				DATE THEREOF <b>6/24/55</b>			
NAME OF CEMETERY OR CREMATORY <b>PARSONS CEMETERY</b>				LOCATION (City, town, or county) <b>SALISBURY, MARYLAND</b>			
DATE REC'D BY LOCAL REGISTRAR <b>6-23-55</b>				REGISTRAR'S SIGNATURE <b>A. C. Hendrick</b>			
FUNERAL DIRECTOR <b>RUSSELL G. THOMAS FUNERAL HOME</b>				ADDRESS <b>1512 HOLLINS STREET, BALTIMORE, MARYLAND</b>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 -- 10 - 53

4204 Area 1  
- 4  
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5398

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>X Cockeysville Md</u>	LENGTH OF STAY (In this place) <u>9 yrs 9 months</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Masonic Home</u>		STREET ADDRESS (If rural give location) <u>3621 Belvedere St</u>	
3. NAME OF DECEASED: (Type or Print) <u>Charles Ezra Snider</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>June 4 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Sept. 12-1867</u>
9. AGE last birthday <u>87</u> yrs. <u>9</u> months <u>9</u> days		10. AGE last birthday IF UNDER 1 YEAR IF UNDER 1 MONTH IF UNDER 1 DAY IF UNDER 1 HOUR IF UNDER 1 MIN.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter Western Md. Dairy</u>		12. BIRTHPLACE (State or foreign country): <u>Westminster Carroll Co</u>	
13. FATHER'S NAME: <u>George Wilmon</u>		14. MOTHER'S MAIDEN NAME: <u>Rebecca Blackstone</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk. (If Yes, give war or dates of service)) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Laura M. Schroeder</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>			<u>1/2 hr</u>
ANTECEDENT CAUSE (B) <u>Cardio Vascular Disease</u>			<u>?</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY	
21E. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Oct. 1947</u> , to <u>June 4, 1955</u> , that I last saw the deceased alive on <u>June 3, 1955</u> , and that death occurred at <u>3 P. M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Walter J. Lees</u>		ADDRESS <u>Cockeysville Md</u> DATE SIGNED <u>6/4/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>6/7/55</u>		NAME OF CEMETERY OR CREMATORY <u>Lorraine Cemetery</u> LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>June 7, 1955</u>		REGISTRAR'S SIGNATURE <u>Laura M. Schroeder</u> 24. FUNERAL DIRECTOR <u>Ann. Cook, St. Paul &amp; Austin St.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BONCAU V. E.

1955

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05404

5399

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>16 Easting Ave</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>3V. 4</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>	
TOWN <u>Baltimore</u>		TOWN <u>Baltimore City</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 The Hotel in the Plains</u>		STREET ADDRESS (If rural, give location) <u>1520 N. Broadway</u>	
3. NAME OF DECEASED (Type or Print) <u>Gloria B. Steen</u>		4. DATE OF DEATH <u>June 2, 1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 18, 1891</u>
9. AGE last birthday <u>64</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore Co. Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>John H. Upman</u>	14. MOTHER'S MAIDEN NAME <u>Anne S. Begold</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY No. <u>none</u>		17. INFORMANT AND ADDRESS <u>Mrs. Regina A. Vogt Catonsville Md.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Myocardial Decompensation</u>		<u>2nd.</u>
Antecedent cause(s) (b) <u>Chronic Cardio-Vascular-Renal Disease</u>		<u>10 yrs.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Diabetes Mellitus</u>		<u>10 yrs.</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/28, 1955, to 6-2, 1955, that I last saw the deceased alive on 6-2, 1955, and that death occurred at 4:50 P m., from the causes and on the date stated above.

SIGNATURE <u>William K. Gallagher M.D.</u>	ADDRESS <u>6209 Frederick Rd. - 28, Md.</u>	DATE SIGNED <u>6-2-55</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Buried</u>	DATE <u>June 6, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery Baltimore</u>
DATE REC'D BY LOCAL REG. <u>6-3-55</u>	REGISTRAR'S SIGNATURE <u>Charles W. Bonfelin</u>	ADDRESS <u>9248 Eagle H.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



5400

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY <u>Baltimore</u> MARYLAND			STATE <u>Maryland</u> COUNTY <u>Baltimore</u>		
CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Mt. Wilson</u> TOWN			CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Lakeland</u> TOWN		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Wilson State Hospital</u>			STREET ADDRESS (If rural give location) <u>2519 Smith Avenue</u>		
3. NAME OF DECEASED: (First) (Middle) (Last) <u>EDWARD A. STEINBACHER</u>			4. DATE (Month) (Day) (Year) OF DEATH. <u>June 9, 1955</u>		
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE WIDOWED. MARRIED. DIVORCED. (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Sept. 25, 1882</u>		9. AGE last birthday <u>72</u> yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Maintenance Man - Md. Glass Corp.</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>Baltimore, Maryland</u>		11. BIRTHPLACE (State or foreign country): <u>U. S. A.</u>
13. FATHER'S NAME: <u>Julius Steinbacher</u>			14. MOTHER'S MAIDEN NAME: <u>Amelia Janusch</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>--</u>		
17. INFORMANT & ADDRESS: <u>Mrs. Bertha Steinbacher, 3220 Hollins Ferry Rd.</u>					

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Far Advanced Pulmonary Tuberculosis</u>		
ANTECEDENT CAUSE (B) <u>DUE TO</u>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: <u>2</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
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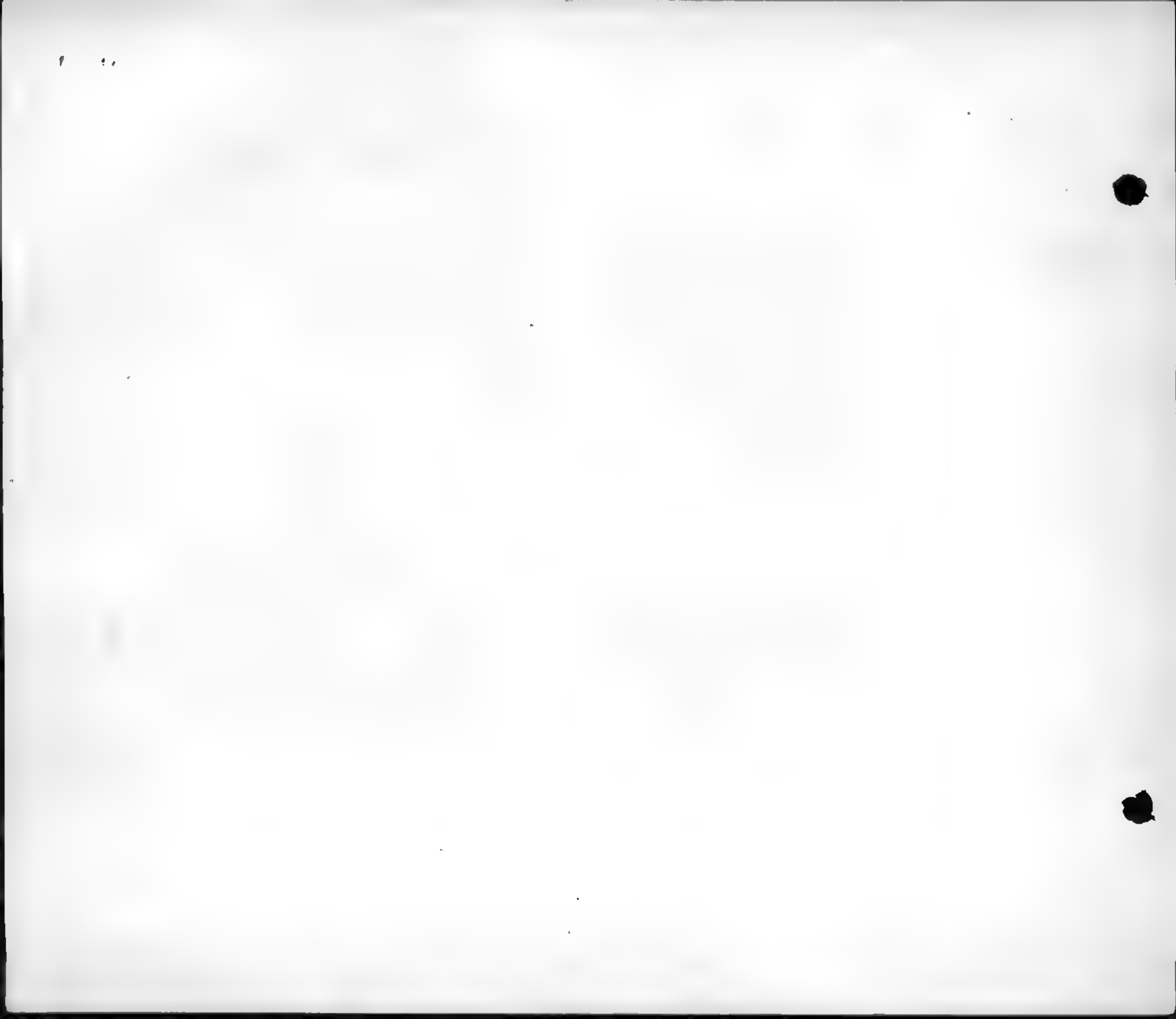
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from July 14, 1954 to June 9, 1955, that I last saw the deceased alive on June 9, 1955, and that death occurred at 8:50 P. from the causes and on the date stated above.

SIGNATURE William Newman M. D. DATE SIGNED June 9, 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>	DATE THEREOF <u>6/13/55</u>	NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Park Cemetery</u>	LOCATION (City, town, or county) (State) <u>Dorsey, Maryland</u>
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DATE REC'D BY LOCAL REGISTRAR <u>6-10-55</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>Wm. Cook, Inc.</u>	ADDRESS <u>1217 St. Paul Street</u>
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05406

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

5401

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CATONSVILLE</u> 5 YRS.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BALTIMORE</u> 20 YRS.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Paradise Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>507 N. ELLWOOD AVE</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>ADA</u> (Middle) <u>AMANDA</u> (Last) <u>STREB</u>	4. DATE OF DEATH	(Month) <u>JUNE</u> (Day) <u>3</u> (Year) <u>1955</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>2-6-79</u>
9. AGE last birthday <u>76</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	13. FATHER'S NAME <u>PETER TILMAN</u>	14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	16. SOCIAL SECURITY NO. (If year, give war or date of service) <u>NONE</u>	17. INFORMANT AND ADDRESS <u>George Streb 15 N. HILTON ST.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>331X Cerebral hemorrhage</u>			<u>5 days</u>
Antecedent cause(s) (b) <u>arterio-sclerosis</u>			<u>3 1/2 yrs.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Paralysed Agitation (Parkinson)</u>			<u>3 1/2 yrs.</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/20, 1951, to June 3, 1955, that I last saw the deceased alive on June 3, 1955, and that death occurred at 4:45 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>6-6-55</u>	<u>London PARK</u>	<u>BALTIMORE MD.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>6-4-55</u>	<u>T.E. Harris</u>	<u>George L. Schwalb</u>	<u>Baltimore, Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
U. S. BUREAU

JUN 7 1951

RECEIVED  
JUN 7 1951

MARYLAND

54-2

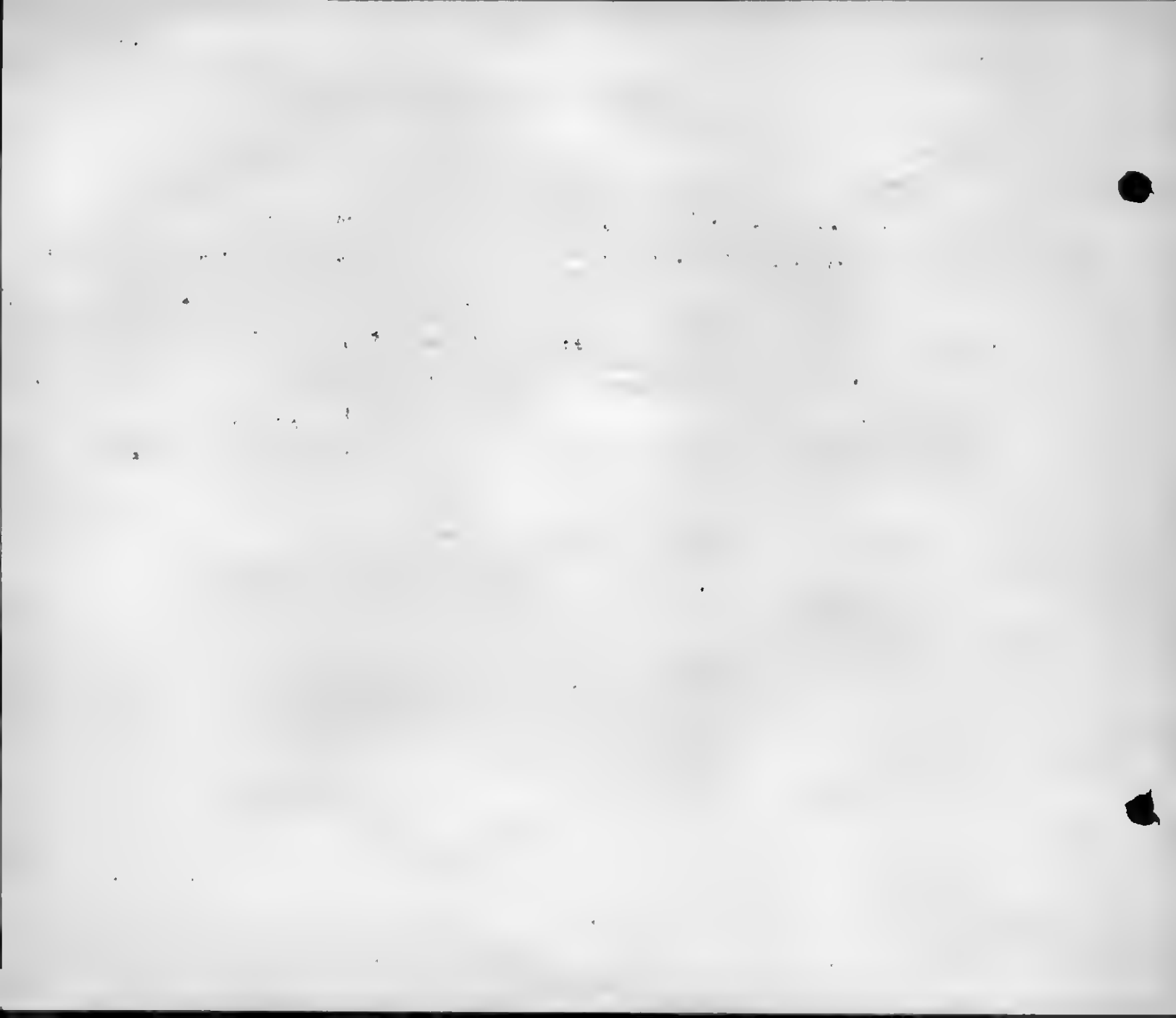
05407  
STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <u>Balto. Co.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville, Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Balto. Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Offott Memorial Home</u>		STREET ADDRESS (If rural, give location) <u>105 S. Catherine St. 223</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>MARIA</u> (Middle) (Last) <u>Stuhler</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>5</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Feb 24 1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NA</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>NOT KNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Frederick Stuhler - Phoenix Md</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>422.1</u> Immediate cause (a) <u>Arteriosclerotic Cardio vascular disease</u> Antecedent cause(s) (b).... Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)....		<u>year</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>unknown</u>	19b. MAJOR FINDINGS OF OPERATION <u>probable malignant bilateral radical mastectomy (fem aco)</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Nov 23</u> , 19 <u>54</u> , to <u>June 5</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>June 4</u> , 19 <u>55</u> , and that death occurred at <u>9:05a</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Elizabeth B. Hanill M.D.</u>		ADDRESS <u>Cockeysville, Md.</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE <u>June 7 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Holy-Rodgers</u>	LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
DATE REC'D BY LOCAL REG. <u>6-7-55</u>	REGISTRAR'S SIGNATURE <u>W. H. Hedrick</u>	24. FUNERAL DIRECTOR <u>W. H. Hedrick</u>	ADDRESS <u>1300 E. Howard Rd - 17</u>

MARGIN RESERVED FOR BINDING



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

5403

05498

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Oella</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Oella</u>	
TOWN <u>Oella</u>		TOWN <u>Oella</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6 Spring St.</u>		STREET ADDRESS (If rural, give location) <u>6 Spring St.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>MARGARET PEARL TAYLOR</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>6-13-55</u> <u>19</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>4-29-1912</u>
9. AGE last birthday <u>43</u> yrs.		10. If under 1 year: Months <u>6</u> Days <u>13</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Oakland, Md</u>		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME <u>Harold Leon Jackson</u>		14. MOTHER'S MAIDEN NAME <u>Anna May Triplett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>213-09-6068</u>	
17. INFORMANT AND ADDRESS <u>H. R. Taylor, Oella, Md</u>			

### 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>420.1</u> <u>Coronary Occlusion</u>	(a) <u>Essential Hypertension</u>	<u>Acute</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Essential Hypertension</u>	<u>10 yrs</u>
(c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 13, 1955, to June 13, 1955, that I last saw the deceased alive on June 13, 1955, and that death occurred at 5:00 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>6-17-1955</u>	NAME OF CEMETERY OR CREMATORY <u>Good Shepherd</u>	LOCATION (City, town, or county) (State) <u>Ellicott City, Md</u>
DATE REC'D BY LOCAL REG. <u>6/16/55</u>	REGISTRAR'S SIGNATURE <u>V.E. Harry</u>	24. FUNERAL DIRECTOR <u>F.C. Higinbotham</u>	ADDRESS <u>Ellicott City, Md</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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19

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5404

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Fort Howard</u>		<u>25 Days</u>		TOWN <u>Baltimore</u> <u>3VJ1.4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>1343 Hull Street</u> ✓			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)					
DAVID B. THOMAS		OF DEATH: <u>June 17, 1955</u>					
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS	
Male	White	Single	10/3/86	68 Years	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Grain Thinner</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Swansea, Wales</u>	
13. FATHER'S NAME: <u>Daniel Thomas</u>				14. MOTHER'S MAIDEN NAME: <u>Sara Jones</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>W.I.</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>THROMBOSIS OF RT. ILIAC &amp; FEMORAL VEINS</u>							
ANTECEDENT CAUSE (B) <u>EMBOLUS &amp; PERI-PROSTATIC VEINS; MULTIPLE PUL.</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							UNKNOWN
(C) <u>GLIOSIS OF DENTATE AND INFERIOR OLIVARY OF NUCLEI OF THE BRAIN</u>							UNKNOWN
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>2</u>				19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 23, 1955</u> to <u>June 17, 1955</u> , and that death occurred at <u>11:05 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William B. VanDeGrift, M.D.</u>				ADDRESS <u>M.D. VAH, FORT HOWARD, MD.</u>		DATE SIGNED <u>6/17/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		June 20, 1955		Baltimore National Cemetery		Balto., Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>June 18 1955</u>		<u>R.W.</u>		William Cook-Blight, Inc., Funeral Home		6009 Harford Rd., Balto., Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Baltimore</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>Baltimore</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>White Hall</i>	LENGTH OF STAY (in this place) <i>3 yrs.</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>White Hall</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Graystone Rd.</i>		STREET ADDRESS (If rural give location) <i>Graystone Rd.</i>	
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH:	
<i>(First) John Vincent (Middle) Thomas (Last) Sr.</i>		DATE (Month) (Day) (Year) <i>June 2 1955</i>	
5. SEX: <i>male</i>	6. COLOR OR RACE: <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>widowed</i>	8. DATE OF BIRTH: <i>Aug. 8, 1888</i>
9. AGE last birthday: <i>66</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>laborer</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Gen Mfg.</i>	
11. BIRTHPLACE (State or foreign country): <i>Pittsburgh Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>unknown</i>		14. MOTHER'S MAIDEN NAME: <i>unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>218-12-82417</i>	
17. INFORMANT & ADDRESS: <i>John Thomas Jr., Whitehall Md.</i>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <i>Cardio - Vascular disease</i>			
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO			
STATING UNDERLYING CAUSE LAST (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <i>0</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22 I hereby certify that I attended the deceased from <i>Apr. 1, 1955</i> , to <i>June 2, 1955</i> , that I last saw the deceased alive on <i>June 1, 1955</i> , and that death occurred at <i>12 M.</i> from the causes and on the date stated above.			
SIGNATURE <i>A. M. France</i>		DATE SIGNED <i>6/3/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>6-4-55</i>	
NAME OF CEMETERY OR CREMATORY <i>Stablersville Meth.</i>		LOCATION (City, town, or county) (State) <i>Parkton, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>6/6/55</i>		REGISTRAR'S SIGNATURE <i>Mr. Howard L. Arkline</i>	
24. FUNERAL DIRECTOR <i>Brooks Funeral Service, Parkton, Md.</i>		ADDRESS <i>L. Scott Brooks</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

1915

1915

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# 5406

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 2

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balt.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balt.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Balt. 10</u>		<u>5 yrs.</u>		TOWN <u>Balt. 10</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1209 Lake Falls Rd.</u>				STREET ADDRESS (If rural, give location) <u>1209 Lake Falls Rd.</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last) <u>THOMAS MAYWELL THOMAS</u>				(Month) (Day) (Year) <u>June 27 1955</u>			
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>married Jan 30 '02</u>		8. DATE OF BIRTH: <u>5:3</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Credit Examiner Bank.</u>		10b. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday: <u>53</u> yrs.		11. BIRTHPLACE (State or foreign country): <u>Spring Grove, Pa.</u>	
13. FATHER'S NAME: <u>Thos. Evan Thomas</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				17. INFORMANT & ADDRESS: <u>Mrs. Lucy Thomas (wife)</u>			
15. SOCIAL SECURITY No.: <u>none</u>				14. MOTHER'S MAIDEN NAME: <u>Ma Morrison</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Shot throat head. (Suicide)</u>						<u>10 min.</u>	
Antecedent cause(s) (b) <u>mental depression</u>							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>10 days.</u>	
19a. DATE OF OPERATION: <u>None</u>						19b. MAJOR FINDING OF OPERATION: <u>None</u>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: <u>Home</u>		21c. (City or town) (County) (State) <u>1209 Lake Falls Rd. Balt. Md.</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>June 27 '55 3:30 PM</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Shot self thru base of skull.</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>X. D. Caples</u>				M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <u>6-27-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF: <u>JUNE 30, 1955</u>		NAME OF CEMETERY OR CREMATORY: <u>Chatham</u>		LOCATION (City, town, or county) (State): <u>Chatham, VA.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE: <u>John O. Mitchell</u>		FUNERAL DIRECTOR: <u>John O. Mitchell</u>		ADDRESS: <u>1800 Eutaw Place</u>	

05411



CERTIFICATE OF DEATH

Reg. Dist. No. 38

Item 2-7, Form 6183 by

1. PLACE OF BIRTH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>—</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>5500</u> OR <u>Howson</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <u>67X-3</u> OR <u>Summit</u>	TOWN <u>67X-3</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>419 Georgia Court</u>		STREET ADDRESS (If rural give location) <u>86 Whitledge Road</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Ralph Alexander Negro</u>		4. DATE OF DEATH: (Month) (Day) (Year) <u>June 20 1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH: (Month) (Day) (Year) <u>1891 717/2</u>
9. AGE last birthday <u>64</u>		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
<u>Retired Salesman Calculating Mach</u>		<u>Hamletown Ohio</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>U.S.A.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME <u>Edmer Negro</u>		14. MOTHER'S MAIDEN NAME: <u>Rose January</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If yes, give year or dates)		16. SOCIAL SECURITY NO. <u>058-05-805</u>	
<u>Yes</u>		<u>1058-05-805</u>	
17. INFORMANT'S ADDRESS: <u>419 Georgia Court</u>		<u>Howson</u>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>332X</u>		DUE TO <u>Cerebral Thrombosis</u>	
ANTECEDENT CAUSE (S)		DUE TO <u>Generalized arteriosclerosis</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C) <u>Gangrene, right leg</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<u>6/18</u>		<u>11:35 AM</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
2 I hereby certify that I attended the deceased from <u>8/6</u> <u>1954</u> to <u>6/20, 1955</u> that I last saw the deceased alive on <u>6/18</u> <u>1955</u> , and that death occurred at <u>11:35 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Laddus C. Sawicki</u>		DATE SIGNED <u>6/20/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>June 22-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>		LOCATION (City, town, or county) (State) <u>Baltimore</u>	
DATE REC'D BY LOCAL REGISTRAR <u>June 22, 1955</u>		REGISTRAR'S SIGNATURE <u>Mabel C. Gray</u>	
24. FUNERAL DIRECTOR <u>John Dunn Sons</u>		ADDRESS <u>Towson</u>	

MARGIN RESERVED FOR BINDING

11-A11-10-51

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ALBERT A. B.

1890

5408

## CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY	BALTIMORE		STATE	MARYLAND	
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		
TOWN	FORT HOWARD	18 DAYS	TOWN	BALTIMORE	
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS		
VETERANS ADMINISTRATION HOSPITAL			2504 CUB HILL ROAD		
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE (Month) (Day) (Year)		
JOHN M. TWELE			JUNE 16 1955		
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	10. UNDER 1 YEAR: 11. UNDER 24 HRS: 12. UNDER 24 HRS: 13. UNDER 24 HRS:
MALE	WHITE	MARRIED	1-11-95	60 yrs.	Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			11. BIRTHPLACE (State or foreign country):		
INSPECTOR			BALTIMORE, MARYLAND		
10B. KIND OF BUSINESS OR INDUSTRY:			12. CITIZEN OF WHAT COUNTRY?		
AIRCRAFT WORK			U. S. A.		
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
FREDERICK W. TWELE			MARY FLAHERTY		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			17. INFORMANT & ADDRESS:		
YES			CLIN. REC., VET. ADM. HOSPITAL, FT. HOWARD, MD.		
16. SOCIAL SECURITY NO.			18. MEDICAL CERTIFICATION		
WW I 216-05-9163			19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
331X			IMMEDIATE CAUSE (A) LEFT CEREBRAL HEMORRHAGE		
ANTECEDENT CAUSE (B)			DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			(C)		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION:			19B. MAJOR FINDINGS OF OPERATION		
6-8-55			LEFT EXPLORATORY CRANIOTOMY AND TRACHEOSTOMY		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		
21C. WHERE DID (City or town) (County) (State)			21D. TIME (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While Not while at work at work			21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from MAY 29, 1955, to JUNE 16, 1955, and that death occurred at 6:20AM, from the causes and on the date stated above.					
SIGNATURE					
WILLIAM B. VANDEGRIFT, M.D.					
M.D. VAH, FORT HOWARD, MARYLAND 6-16-55					
23. BURIAL, CREMATION, REMOVAL (SPECIFY)					
BURIAL JUN. 18, 1955					
LOCATION (City, town, or county) (State)					
BALTIMORE COUNTY, MD.					
24. FUNERAL DIRECTOR					
John Burns' Sons Funeral Home					
612 York Road, Baltimore 4, Md.					

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7/8 100000

## MARYLAND STATE DEPARTMENT OF HEALTH

05414

2411 N. Charles Street, Baltimore

5285

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH - COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>MD</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>51</u> TOWN <u>Halethorpe</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>51</u> TOWN <u>Halethorpe</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1724 Selma Ave</u>		STREET ADDRESS (If rural, give location) <u>1724 Selma Ave</u>	
3. NAME OF DECEASED (First) <u>Harry</u> (Middle) <u>Diebold</u> (Last) <u>Vehstedt</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>29</u> (Year) <u>1953</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug 21 - 1889</u>
9. AGE last birthday <u>67</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief Clerk</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. R.R.</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore City</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Herman Martin Vehstedt</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ruth Ruediger</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>705-05-3147</u>	
17. INFORMANT AND ADDRESS <u>Mrs Violet Vehstedt (Wife) 1724 Selma Ave</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
443X Immediate cause (a) <u>Cerebral Myocarditis &amp; degeneration</u>		<u>19 mo</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Arterial Hypertension</u>		<u>5 yrs</u>	
(c) <u>General arteriosclerosis</u>		<u>5 yrs</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Hemiplegia, rt</u>		<u>1 yr</u>	
19a. DATE OF OPERATION <u>6</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u> PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u> (CITY OR TOWN) (COUNTY) (STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u> INJURY OCCURRED While at <input type="checkbox"/> Not While <input type="checkbox"/> Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July</u> , 193 <u>4</u> , to <u>June 29</u> 19 <u>53</u> , that I last saw the deceased alive on <u>June 28</u> , 19 <u>53</u> , and that death occurred at <u>9:30 a</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Dr. B. Brumbaugh</u>		DATE SIGNED <u>4/29/53</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u> DATE THEREOF <u>JUL 2 1953</u> NAME OF CEMETERY OR CREMATORY <u>LORRAINE PARK</u> LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>			
DATE REC'D BY LOCAL REG. <u>1-55</u> REGISTRAR'S SIGNATURE <u>W. J. ...</u>		24. FUNERAL DIRECTOR ADDRESS <u>1324 SULPHUR ST. R.D.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



5499

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		X	
X TOWN <u>Chase, Ind.</u>		<u>13 years</u>		TOWN <u>Chase Ind.</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
—				<u>2553 Eastern Ave. 2nd.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>CHARLES HARDEE WALLER</u>				<u>June 4 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>M.</u>	<u>W.</u>	<u>Widowed</u>	<u>August 16, 1867</u>	<u>87</u> yrs.	<u>8</u> Months	<u>16</u> Days	<u>11</u> Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>pen artist</u>				<u>pen artist</u>		<u>Baltimore, Md.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Theodore Waller</u>				<u>?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>9</u>							
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
4.50.0							
IMMEDIATE CAUSE						(A) <u>Hypostatic pneumonia.</u>	
ANTECEDENT CAUSE (B)						(B) <u>Generalized arteriosclerosis</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						(C) <u>primary destruction - prostatic hypertrophy</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<u>—</u>				<u>—</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan.</u> , 19 <u>55</u> , to <u>June</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>June 4</u> , 19 <u>55</u> , and that death occurred at <u>10:15 P.</u> M., from the causes and on the date stated above.							
SIGNATURE				ADDRESS		DATE SIGNED	
<u>—</u>				<u>M. D. Dr. P. Douglas, D.O.</u>		<u>June 4, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5/8/1955</u>		<u>LOUDON PARK</u>		<u>BALTO MD</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>6-7-55</u>		<u>—</u>		<u>John G. Connelley, Essex, Ind.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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05416

MARYLAND 5410

STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

Item 9, Film GL83 6-27-55 et

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>...</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN RANDALLSTOWN</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1806 Thomas Avenue</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Loda Gertrude Walters</u>		4. DATE OF DEATH <u>June 11, 1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Sept. 8, 1878</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William T. Belt</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Stansbury</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mrs. Harry E. Wolf-Old Court Road</u>	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
170X Immediate cause (a) <u>CARCINOMA OF BREAST - METASTASIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 YRS</u>	
Antecedent cause(s) (b) <u>TO LUNG - LEFT -</u> <u>CARCINOMA OF BLADDER - METASTASIS</u> <u>TO PELVIC BONES &amp; CERVICAL SPINES.</u>		<u>10 MOS.</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. (c) <u>CONGESTIVE HEART FAILURE &amp; PULMONARY EDEMA.</u>		<u>2 DAYS</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>APRIL 1, 1954</u> , to <u>JUNE 11, 1955</u> , that I last saw the deceased alive on <u>JUNE 11, 1955</u> , and that death occurred at <u>7 P.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Thomas E. Wheeler</u>		ADDRESS <u>M.D. 3601 Elmhurst Rd - Baltimore - Md.</u>	
DATE SIGNED <u>6-11-55</u>			
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>6-14-1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Mount Olive Cemetery</u>		LOCATION (City, town, or county) (State) <u>Randallstown, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>6-13-55</u>		24. FUNERAL DIRECTOR <u>Ellsworth Armacost</u>	
REGISTRAR'S SIGNATURE <u>Ellsworth Armacost</u>		ADDRESS <u>4600 Liberty Heights Avenue</u>	

MARGIN RESERVE FOR BINDING



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harrison</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harrison</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) <u>Reisterstown Road</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Ida Elizabeth Wantz</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 3 1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>H.W.</u>	8. DATE OF BIRTH <u>28 March 1870</u>
9. AGE last birthday <u>85</u> yrs.		10. If under 1 year: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>H.W.</u>	
11. BIRTHPLACE (State or foreign country) <u>Carroll County, Dist., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George W. Phillips</u>		14. MOTHER'S MAIDEN NAME <u>Martha Brown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT <u>Stewart Wantz - husband</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>422.1</u> Immediate cause (a) <u>Arteriosclerotic CVD</u> Antecedent cause(s) (b) _____ Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>-0-</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) _____ SUICIDE _____ HOMICIDE _____		PLACE (Home, farm, factory, street, OF office bldg., etc.) _____ (CITY OR TOWN) _____ (COUNTY) _____ (STATE) _____	
TIME (Month) (Day) (Year) (Hour) OF INJURY _____ m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>10 July</u> , 19 <u>53</u> , to <u>3 June</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3 June</u> , 19 <u>55</u> , and that death occurred at <u>2:30 P.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Charles N. Wilkins, M.D.</u>		ADDRESS <u>Pikesville 8, Md.</u> DATE SIGNED <u>3 June 55</u>	
23. BURIAL, CREMATION OR REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>6/6/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		LOCATION (City, town, or county) (State) <u>Balto.</u>	
DATE REC'D BY LOCAL REG. <u>June 4 1955</u>		REGISTER'S SIGNATURE <u>RW</u>	
24. FUNERAL DIRECTOR <u>Young &amp; Sons</u>		ADDRESS <u>5005 Pk. Heights Rd. Balt. 15, Md.</u>	

5411

05417



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5279

05418

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 41

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN	
TOWN <u>DUNDALK 821</u>		<u>33 YRS</u>		TOWN <u>Baltimore 122</u>		<u>52</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 LIBERTY PKWY.</u>				STREET ADDRESS (If rural, give location) <u>14 Liberty Parkway</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
(Type or Print) <u>JOHN MICHAEL WEISS</u>				<u>6 17 55</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>SINGLE</u>		8. DATE OF BIRTH: <u>5 NOV 67</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>MISCELLANEOUS</u>		9. AGE last birthday: <u>67</u> yrs.		11. BIRTHPLACE (State or foreign country): <u>MD.</u>	
13. FATHER'S NAME: <u>MICHAEL WEISS</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
14. MOTHER'S MAIDEN NAME: <u>ELIZABETH UHL</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service) <u>—</u>			
16. SOCIAL SECURITY No.: <u>1</u>				17. INFORMANT & ADDRESS: <u>MRS. JAMES L. FLOYD - SAME ADDRESS</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a)..... <u>Arteriosclerotic cardiovascular disease</u> DUE TO							
Antecedent cause(s) (b)..... <u>Coronary occlusion</u> DUE TO							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>2</u>				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>William M. Kelly</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>6/17/55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF <u>6-20-55</u>		NAME OF CEMETERY OR CREMATORY <u>BALTIMORE</u>		LOCATION (City, town, or county) (State) <u>BALTO., MD.</u>	
DATE REC'D BY LOCAL REG. <u>June 17-1955</u>		REGISTRAR'S SIGNATURE <u>William M. Kelly</u>		24. FUNERAL DIRECTOR <u>Walter Brooks</u>		ADDRESS <u>Baltimore, Md.</u>	

W. A. DUNN

1911

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5412

05419

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County..... Baltimore Co  
 City or town..... Essex  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 5 Years  
 Hospital, institution, or street address where death occurred:  
 60  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Maryland County..... Baltimore  
 City or town..... Essex  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 430 Riverview Road  
 (If rural, give LOCATION)  
 \*\*\*  
 2(a) If veteran, name war .....

## 3. (a) FULL NAME

James Corum Wilhelm

## 3. (b) Social Security Number

705-05-5995

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife..... Jessie (Beatty) Wilhelm

6. (c) If alive, give age..... years

## 7. Birth date of deceased (mo., day, yr.)

June 15, 1884.

## 8. AGE:

Years

Months

Days

If less than one day

71'

\*

\*

hrs.

min.

## 9. Birthplace

Baltimore Md

(Town, county, and state)

## 10. Usual occupation

Clerk (Retired)

## 11. Industry or business

Railroad

## FATHER

## 12. Name

John Wilhelm

## 13. Birthplace

## MOTHER

## 14. Maiden name

Jeanette Clark

## 15. Birthplace

## 16. Informant

Mrs Jessie Wilhelm (Wife)

## Address

430 Riverview Rd. Essex Baltimore 25 Md

## 17.

(Burial, cremation, or removal. Which?)

Date thereof..... June 18, 1955  
 (month) (day) (year)

## Cemetery or crematory

New Cathedral Cemetery

## Location

Baltimore Md

## 18. Funeral director

J Melville Jenkins

## Address

2713 Kirk Ave Baltimore Md

## 19.

(Date rec'd by registrar)

19

6-12-55

Regist

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 15, 1955, at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 23, 1955, to June 10, 1955

and that I last saw him alive on June 10, 1955

Immediate cause of death

Coronary Arteriosclerosis

## DURATION

1 week

Due to

Renalized Arteriosclerosis 20 yrs

Due to

Other conditions

331 X

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. ....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury

Injured at work?

23. SIGNATURE

Harry B. Smith, M.D. or other  
 Address 413 E. E. Ave. Balt 21 Date signed 6-16-55



06461

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 45

5413

1. PLACE OF DEATH- COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Balto 20.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Balto 20</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>#506 Seneca Park Rd</u>		STREET ADDRESS (If rural, give location) <u>#506 Seneca Park Rd</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Stephen</u> (Middle) <u>A</u> (Last) <u>WILKINSON</u>	4. DATE OF DEATH (Month) <u>June</u> (Day) <u>29</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 8-1879</u>
9. AGE last birthday <u>75 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Own Business</u>		11. BIRTHPLACE (State or foreign country) <u>Balto Co. md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Stephen A. Wilkinson</u>	
14. MOTHER'S MAIDEN NAME <u>Mary T. Frauser</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY No. <u>NO</u>		17. INFORMANT AND ADDRESS <u>Mrs Stephen A. Wilkinson #506 Seneca Park Rd</u>	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause <u>Carcinomatosis, generalized</u>		<u>4 months</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(b) <u>Site of primary, undetermined</u>	
(c) <u>Conjunctive heart failure</u>		2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>3 weeks</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		21. ACCIDENT SUICIDE HOMICIDE (Specify)	
PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)	
INJURY		(COUNTY)	
TIME (Month) (Day) (Year) (Hour)		HOW DID INJURY OCCUR?	
INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <u>Sept 4, 1952</u> to <u>June 29, 1955</u> , that I last saw the deceased alive on <u>June 27, 1955</u> , and that death occurred at <u>11 a.m.</u> from the causes and on the date stated above.			
SIGNATURE <u>W. Fuller MD</u>		ADDRESS <u>Ridge Rd Baltimore 6 md</u>	
DATE SIGNED <u>June 29/55</u>			
23. BURIAL CREMATION REMOVAL (Specify) <u>Buried</u>		DATE THEREOF <u>7/2/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Parkwood Cem</u>		LOCATION (City, town, or county) (State) <u>Balto md</u>	
DATE REC'D BY LOCAL REG. <u>7/6/55</u>		REGISTER'S SIGNATURE <u>Gail Shirley</u>	
24. FUNERAL DIRECTOR <u>Lassahn Funeral Home 7401 Belair Rd.</u>		ADDRESS	

MARGIN RESERVED FOR BINING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. F. L. Fox

RECEIVED

11 21 11

11 21 11

5414

## CERTIFICATE OF DEATH

Reg. Dist. No. 05420

## 1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND  
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Life

HOSPITAL OR INSTITUTION OR STREET ADDRESS

00 3322 Washington Blvd.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Baltimore  
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X

STREET ADDRESS (If rural give location)

3322 Washington Blvd.

3. NAME OF DECEASED:  
(Type or Print)

SARAH

(First)

(Middle)

J.

(Last)

WILSON

4. DATE

(Month)

(Day)

(Year)

OF DEATH:

June

5

1955

5. SEX:

Female

6. COLOR OR RACE:

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

Widowed

8. DATE OF BIRTH:

Oct. 18, 1872

9. AGE last birthday:

82 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS

Months Days Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):

Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

At Home

11. BIRTHPLACE (State or foreign country):

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

John M. Gerber

14. MOTHER'S MAIDEN NAME:

Sarah E. Meyers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)

No

16. SOCIAL SECURITY NO.:

—

17. INFORMANT &amp; ADDRESS:

John M. Barton 5th Ave. Landdown

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) ACUTE CORONARY OCCLUSION

DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) ...

DUE TO

(c)

Interval Between Onset And Death

2 1/2 hrs

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY ?

Yes ☐ No ☒

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from MAY 4, 1954, to MAY 25, 1955, that I last saw the deceased

alive on MAY 25, 1955, and that death occurred at 1:00 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

C. Arthur Rosenberg M.D. 2436 Washington Blvd. Balto. 30 Md. 6/7/55  
Burial June 8, 1955 London Park Baltimore, Md.  
7. B. Wippet 1300 Eutaw Place

Dunn

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2000

2

2

5415

## CERTIFICATE OF DEATH

Reg. Dist. No. 3/

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Balto Co</i>	MARYLAND	STATE <i>Md</i>	COUNTY <i>Balto</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<i>X</i> TOWN <i>Randallstown</i>	<i>9 Mo</i>	TOWN <i>Randallstown</i>	<i>X</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<i>100 North Chapman Road</i>		<i>North Chapman Road</i>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(Type or Print)	(First) (Middle) (Last)	(Month) (Day) (Year)	
<i>Mary</i>	<i>B</i>	<i>June 16</i>	<i>1955</i>
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<i>Female</i>	<i>White</i>	<i>Widowed</i>	<i>Sept 29/1880</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):
<i>Housewife</i>		<i>Home</i>	<i>Phila Pa</i>
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<i>Newton B. Broad</i>		<i>Adaline G. Belsterling</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS:			
<i>Newton B. Broad</i>		<i>Randallstown Md</i>	
18. MEDICAL CERTIFICATION:			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>422.1 Cardio-vascular Disease</i>			
DUE TO			
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY?			
YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, of injury street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While at work Not while at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>6/1/55</i> , to <i>6/16/55</i> , that I last saw the deceased alive on <i>6/16/55</i> , and that death occurred at <i>1250 M</i> , from the causes and on the date stated above.			
SIGNATURE <i>Thos. E. Martin M.D.</i>		ADDRESS <i>Randallstown</i>	DATE SIGNED <i>6/16/55</i>
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>June 18/55</i>	<i>Wood Fidge</i>	<i>Pikesville Md.</i>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	CO. FUNERAL DIRECTOR	ADDRESS
<i>6/16/55</i>	<i>Thos. E. Martin</i>	<i>Harry H. Amason</i>	<i>4204 Ridgewood Ave.</i>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8 A 114000

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80/10

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05421

5280

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Har.</u>
CITY (If outside corporate limits, write RURAL or nearest town) <u>53 Dundalk</u>	LENGTH OF STAY (in this place) <u>7 yrs.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>53 Dundalk</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>118 Antenor Ter.</u>		STREET ADDRESS (If rural give location) <u>118 Antenor Ter.</u>	
3. NAME OF DECEASED: (Type or Print) <u>Ellen W. Johnson</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>JUNE 24 19 55</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED: <u>Widowed</u>	8. DATE OF BIRTH: <u>Aug 10 01</u>
9. AGE last birthday IF UNDER 1 YEAR IF UNDER 1 YEAR		10. AGE last birthday IF UNDER 1 YEAR IF UNDER 1 YEAR	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>	
11. BIRTHPLACE (State or foreign country): <u>None</u>		12. CITIZEN OF WHAT COUNTRY? <u>None</u>	
13. FATHER'S NAME: <u>John W. Johnson</u>		14. MOTHER'S MAIDEN NAME: <u>Ellen V. Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMY OR NAVAL SERVICE? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT'S ADDRESS: <u>118 Antenor Ter.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>420.1 Coronary Thrombosis</u>		<u>10 days</u>	
ANTECEDENT CAUSE (S) <u>Arteriosclerotic C.V. disease</u>		<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST			
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>None</u>		19B. MAJOR FINDINGS OF OPERATION: <u>None</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY OCCUR? <u>None</u>	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <u>None</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>None</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? <u>None</u>			
22. I hereby certify that I attended the deceased from <u>June 1, 19 55</u> to <u>June 24, 19 55</u> that I last saw the deceased alive on <u>June 24, 19 55</u> , and that death occurred at <u>4 P</u> M. from the causes and on the date stated above.			
SIGNATURE <u>Jeffrey C. Mackenbach</u>		DATE SIGNED <u>6/24/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>JUNE 27, 55</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Ignace</u>		LOCATION (City, town, or county) <u>Baltimore</u>	
DATE REC'D BY LOCAL REGISTRAR <u>June 25, 1955</u>		REGISTRAR'S SIGNATURE <u>R.W.</u>	
24. FUNERAL DIRECTOR <u>St. Ignace</u>		ADDRESS <u>6067 Traylor Rd</u>	

Dr. [illegible]  
17th St. [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5416

CERTIFICATE OF DEATH

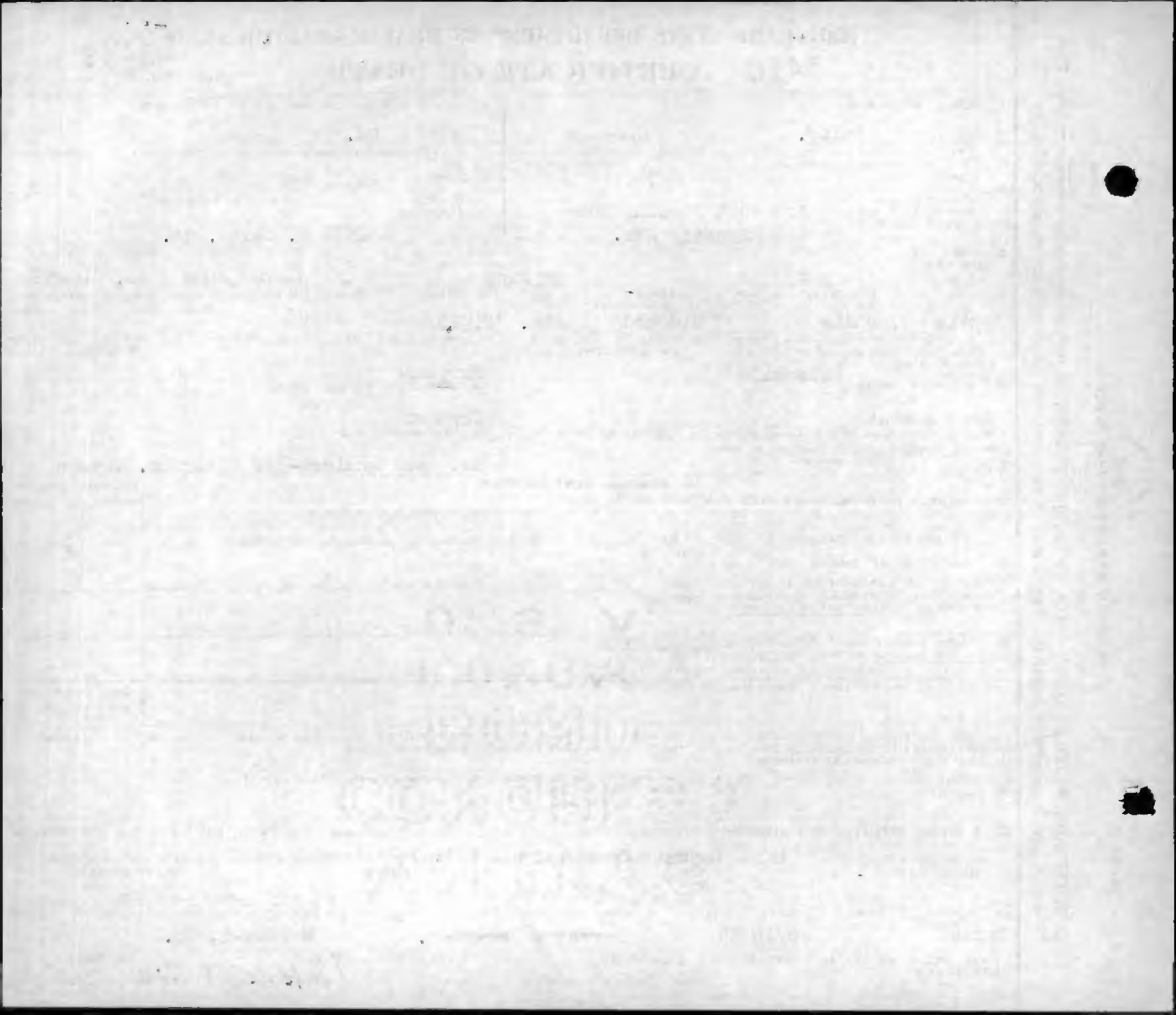
Reg. Dist. No.

054228

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Balto.</b>	MARYLAND	STATE <b>Md.</b>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) <b>X</b> TOWN	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Baltimore</b>	<b>3101-4</b>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>90 Armacost Nursing Home 812 Regester Ave.</b>		STREET ADDRESS (If rural give location) <b>2552 W. Balto. St.</b>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <b>MARY</b>	(Middle) <b>WULFERT</b>	(Day) <b>June 11,</b>	(Year) <b>1955</b>
5. SEX: <b>Female</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>	8. DATE OF BIRTH: <b>Aug. 22, 1878</b>
9. AGE last birthday: <b>76</b> yrs.		10. BIRTHPLACE (State or foreign country): <b>Maryland</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Housewife</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <b>James Shabek</b>		14. MOTHER'S MAIDEN NAME: <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <b>Mr. Jack Wulfert-317 Dixie Dr. Towson</b>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <b>420.1</b>		<b>2 days</b>	
ANTECEDENT CAUSE (5)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <b>Coronary Thrombosis</b>			
(B) <b>Hypertensive Cardio-Renal</b>			
(C) <b>Vascular Disease</b>		<b>10 yrs.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <b>0</b>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>June 11, 1955</b> , to <b>June 11, 1955</b> , that I last saw the deceased alive on <b>June 11, 1955</b> , and that death occurred at <b>6:20 P.M.</b> from the causes and on the date stated above.			
SIGNATURE <b>Charles F. Donaldson</b>		DATE SIGNED <b>6/13/55</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>6/14/55</b>	
NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cem.</b>		LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>6-13-55</b>		REGISTRAR'S SIGNATURE <b>Wm. J. Dickner</b>	
FUNERAL DIRECTOR <b>Wm. J. Dickner</b>		ADDRESS <b>4001-4</b>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5417

05423  
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Catonsville</u> LENGTH OF STAY (in this place) <u>11 yr. 5 mo. 13 days</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>	STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Benges</u> STREET ADDRESS (If rural, give location) <u>Bowleys Quarter Road</u>		
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>Melvin O. MIECZYSLAW Zurek</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 20, 19 55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>8-4-1904</u>
9. AGE last birthday: <u>50</u> yrs.		IF UNDER 1 YEAR: Months _____ Days _____	IF UNDER 24 HRS.: Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Farms</u>	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME: <u>Peter Zurek</u>	
14. MOTHER'S MAIDEN NAME: <u>Dorothy Kubick</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): (If Yes, give war or dates of service) <u>Unknown</u>	
16. SOCIAL SECURITY No.: <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hospital</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: Immediate cause (a) <u>Acute cardiac failure</u> DUE TO Antecedent cause(s) (b) <u>Arteriosclerotic heart disease</u> Diseases or conditions, if any, giving rise to the above cause DUE TO Stating underlying cause last (c) <u>General Paresis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>420.0</u>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: <u>6-20-55</u>		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M. _____	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>Geo. J. McKieffer</u> <u>Exam. Balto.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>6-20-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF: <u>6/24/55</u>	NAME OF CEMETERY OR CREMATORY: <u>Holy Rosary</u>	LOCATION (City, town, or county) (State): <u>Balto., Cor. Md.</u>
DATE REC'D BY LOCAL REG. <u>6-20-55</u>	REGISTRAR'S SIGNATURE: <u>A. W. K. [Signature]</u>	24. FUNERAL DIRECTOR: <u>Wm. S. Fialkowski 2007 Eastern Ave</u>	

